PUBLIC HEALTH NURSING

AUGUST
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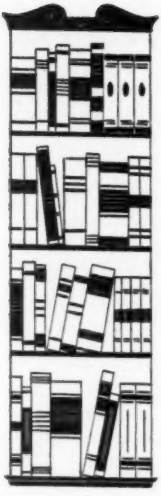

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

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Meat... and the Role of Protein in Resistance to Infectious Disease

According to accumulated evidence, an adequate intake of high biologic-quality protein is needed for the generation[1] and active phagocytic functioning of leukocytes[2,3] and lymphocytes as well as for the fabrication of effective amounts of antibody globulin.[4] Both the natural and the acquired capacities of the body to counteract the pathologic stimuli of infectious disease, in considerable measure, hinge on adequate protein nutrition.[5]

Substantiating the foregoing clinical conviction, recent studies have demonstrated that protein-depleted animals subjected to pathologic stimuli display a greatly lowered capacity for manufacturing specific antibodies.[6] Conversely, repletion of their protein stores with high-quality protein quickly restores a normal capacity for antibody production. Furthermore, protein-depleted animals are both more susceptible to induced infection and less responsive to immunization than those well nourished.

Findings such as these and the fact that human antibody globulin is a highly complex protein containing all the essential amino acids justify the following authoritative deductions[6]:

a. Lacking an adequate supply of essential amino acids, the body manufactures antibody globulin with difficulty, and

b. Because of depleted protein reserves and inadequate intake of essential amino acids, persons long and seriously undernourished manifest increased susceptibility to infection due to inability to fabricate new supplies of antibody globulin.

Because of its rich content of high biologic-quality protein providing all the essential amino acids, meat can play a prominent role in maintaining the body's resistance to infection both in health and disease. Meat can be eaten in adequate quantity daily to assure a significant intake of biologically complete protein.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

New Goals Are Achieved

THE NOPHN EXECUTIVE Committee at its meeting in May with the Board of Directors of the National League of Nursing Education agreed that the Articles of Incorporation and Bylaws of the NLNE would be revised for the founding of the new Nursing League of America. (See page 463). This plan was reached at the request of the Joint Coordinating Committee on Structure after the most thoughtful consideration of all details involved and with the guidance of legal counsel. It calls for the eventual transfer of NOPHN's assets (including its members, both agency and individual) and much of its work to the new Nursing League of America. NOPHN members will make the final decision at the Biennial Convention to be held in Atlantic City in June 1952. According to previous decisions the present ANA Constitution and Bylaws will become the nucleus for the new American Nurses' Association.

A Committee on Agreements, with representatives from the NOPHN and the NLNE, as well as from the American Association of Industrial Nurses and the Association of Collegiate Schools of Nursing—since these groups are closely involved in the plans—was formed to work out details. Agreements satisfactory to the boards of directors and memberships of all the organizations concerned will be made before any action toward this change is taken. This is an important step in the reorganization of the national nursing organizations. The accent will be on strengthening programs and work and continuing all important projects of the present "nationals."

In the future there will be more coordinated, and we hope increased, services available for individual members, agencies and institutions, and communities. In short, organizational programs will be enriched if we all stand together now.

As the skeletal plan for reorganization, which received membership approval at the 1950 Biennial Convention, takes on dimensions and becomes a possibility it is natural that some questions, some confusions, may arise in the minds of some members. This is a time that calls for optimism and trust. We must not go aground because of misunderstandings, especially those due to semantics. Every detail will not be clear to everyone immediately. But every detail has been or will be considered and weighed, and all members will have a chance to vote on major changes to be made. All present members of the NOPHN must understand this.

It is not too early to think about one's own place in the future organization. Every active member of the NOPHN — individual and agency—will be transferred when the day for launching the new Nursing League of America arrives. It makes us pause when we think that each one of us thus has the privilege of being a charter member of the NLA. Yes, it is not too early to think about this and to determine to give support in every way we know to the new organization. The first evidence of our interest and support is to keep up our present membership and to try to win new members who also will support services we sincerely believe in.

The structure committees have worked arduously to fulfill their responsibility to have a finished plan ready to be voted on by the members when they meet together for the Biennial Convention in Atlantic City in June 1952. They have sometimes been asked to show the judgment of Solomon. We can all be proud of what they are achieving in our interests.

We have come a long way together, step by step, toward a goal that at times seemed nebulous. Now the goal draws near and the outlines become clear. It holds forth bright promise.

A Nurse Visitor in India

D. LOIS BURNETT, R.N.

INDIA WAS STRANGELY different from America. In fact, one could easily believe that the Westerner's expression "out of this world" could have originated here. There was such a sense of strangeness about everything that one could easily imagine being in another world.

Strange! Fascinating! Appealing! This land of India! A land where leisurely appearing people stop to show a friendly interest in what you are doing, and to look at your white face and American clothes. Where the people are so stoical that their faces register little expression of happiness. Where women enhance their loveliness by draping themselves in the graceful folds of their saris. Where men drape their lower extremities with a long white cloth (called a dhoti) and wear shirttails hanging out. Where many go barefoot and children are often nude. Where the shops are generally small, open-front buildings, and where bargaining is done with great skill. A land where there is comparatively little waste, and where cow dung is dried and used for fuel and for a floor finish of the poorer homes. A land where women carry loads on their heads. Where beggars persistently follow one with a chant-like request. Where ox-drawn carts and two-wheeled horse-drawn tongas provide the principal means of transportation. Where there are few telephones, and local communication is carried on by written notes (chits) conveyed by servants. Where lepers walk down the street and mingle with the nonleprous. Where many have disfiguring marks from smallpox. Where rice is the most commonly used food and curry is relished as a seasoning! Where banana leaves make an attractive substitute for table china and minimize dish washing. Where there is an abundance of manpower, and salaries for manual labor are pitifully low.

It was my privilege to increase my knowledge of nursing and nursing education needs in India by having conferences with several leaders in health work, the first of which was with Rajakumar Amrit Kaur, the minister of health. She is a Christian and comes from one of the most prominent families in India. She is highly educated, although not medically trained, and is keenly interested in the health work being done for India by mission groups. Due to the abundant labor supply throughout the country a large proportion of people in public service are men. Rajakumar Amrit Kaur had five secretaries in her office, all men.

There are two schools of nursing in India with degree-conferring curriculums, one of which is in Delhi, the Government College of Nursing of the University of Delhi. It was my good fortune to be the guest of Miss Margaretta Craig, dean of this school of nursing, and to visit this teaching center, one of the best educational programs in nursing in India.

Leaving Delhi by train we went north to Ludhiana to visit the school of nursing of the Women's Missionary College. This 314-bed hospital was started in 1894 by Dr. Brown, a Baptist missionary woman physician. Before the "Partition" many of the people of this area were Moslem and, of course, their womenfolk were in purdah (veiled from view of men). During this period the mission hospital had endeavored to meet the health needs of women by providing medical service rendered entirely by women physicians and women nurses. Also to facilitate the meeting of this need the college educated only women physicians, nurses, and other female person-

nel. At the time of the "Partition" the riots were very severe in this area, and the demand for hospital care for men increased to such an extent that the hospital became a general hospital for men and women. Now the plan is to continue medical services for both sexes, as the Moslem women for whom the purdah services were essential have now migrated to Pakistan.

THERE WERE STILL visible evidences of the riots which had taken place at the time of the "Partition." As the train approached Ludhiana a gray stack about eight feet high could be seen, and someone explained that these were bones accumulated during the riots. In the hospital a section of the children's ward had been set aside for well babies and small children who had been left orphans following the riots. The nurses had watched carefully for words and mannerisms of the children which would give a clue to their identity, including the religious group to which they had belonged. After they puzzled for weeks over one especially bright two-year-old, the child revealed her previous thorough religious training by saying, "La Illaha illa Allah wa Mohammed Russul Allah," which was interpreted as meaning "No God except God and Mohammed is the messenger of God." Many had become homeless as the result of the riots and the mass migration which followed the "Partition," and there were literally acres of tent villages in the area of Ludhiana. These conditions have greatly intensified the health needs of India.

The train trip itself was full of interest. As soon as we reached the railroad station, red-turbaned coolies surrounded us begging to carry the baggage which consisted not only of hand bags but bedding rolls and tiffins (lunch boxes) for the railway passenger in India must be entirely self-sustaining. Although India is a country of much malnutrition the coolie exhibited what seemed like superhuman strength as he placed two heavy suitcases and a bedding roll on his head, and walked off as lightly as if carrying one average weight suitcase.

A first night on a train in India provides so much interest at each station stop that it would be a pity to miss any of it. There were always crowds of people excitedly trying to board the train, food and betel-nut vendors, and also the sleeping forms of travelers or homeless people stretched out on the platform or near the station, covered from head to foot with a cloth. At daybreak the scene changed somewhat, for many of those who were not boarding the train were near the end of the station platform, grooming themselves for the day. Soap is not in common use, but there is much throwing of water over the face and head from the individual's brass water container, or washing at the railroad station's water supply. Teeth are brushed using a certain type of stick which can be frayed to give it brush-like qualities. The gagging sound which accompanies the mouth hygiene elicits as much sympathy as for one in deep physical distress —that is, until you are oriented to the sounds and customs of the country.

At the railroad station there are two water supplies. One is marked *General*, and the other *Orthodox*. Since the "Partition" between the Mohammedans and Hindus the people are trying to develop a communal spirit in contrast to the previous practice of having one water supply marked *Mohammed* and the other *Hindu*. It seems the Mohammedans would have used either supply, but the Hindus would not use anything used by the Mohammedans.

It was 4:30 a.m. when we arrived in Miraj to visit the Miraj Medical Center. Like many others waiting at the station, we too found a bench and slept until daybreak. The Miraj Medical Center consists of a large general hospital, a 400-bed tuberculosis hospital, a leper colony for 150 patients, a school of medicine, and a school of nursing. The patients in the colony were a pitiful sight with their varying degrees of disfigurement, but most of them were responding favorably to the treatments they were receiving.

The caste system, which was formerly very strictly observed, has resulted in certain customs which are peculiar to many hospitals or certain wards of the hospitals. These include the companionship of one or more members of a patient's family during the hospitalization period to help wait on the patient

and to provide the patient's food. Although the granting of these privileges to the patients' families relieves the hospital of the expense of the dietary service and some hours of nursing service, it also creates greater problems, such as difficulty in providing the proper diet for the patient and maintaining cleanliness in the hospital and quiet, uncrowded conditions in the wards.

THE ITINERARY INCLUDED a stop at the Vellore Medical College, where there are three different programs in nursing—a degree-conferring curriculum in the basic professional course in nursing, a so-called "higher grade training" in the basic course in nursing leading to a diploma, and a course for graduate nurses to prepare them for faculty positions in schools of nursing. The latter is called a sister-tutor course. The medical missionary service of several generations of the Scudder family has contributed much to the development and progress of the Vellore Medical College and the hospital operated in connection with the college. There is also a school of medicine here. This college offers training for "compounders," which qualifies the students to take the licensing examination for this work. A compounder is a person equipped with an empirical type of medical preparation to meet some of the simpler health needs of the people in areas where there is an acute need for medical service.

Leaving Vellore we traveled sixteen miles by bus to Ranipet to visit the Scudder Memorial Hospital. Life in India is not complete until one has taken a trip on one of the local buses. This bus was not operated by gasoline, but by a charcoal burner which was at the rear of the bus. Now and then the bus had to stop and someone went to the back and stoked the charcoal fire to make it burn. The bus was crowded to the limit, but there always seemed to be room for another passenger as long as there was squatting room on the floor.

A so-called "higher grade" school of nursing is conducted here at the Memorial Hospital, headed by Dr. Galen Scudder. At the rear of the mission compound is a separate building for communicable disease patients. At the time of my visit they had four cholera patients. We went next to the seacoast city of Madras, quite modern in many respects. Here there is a 1,000-bed government hospital with a school of nursing.

It had been arranged for me also to visit a "lower grade" school of nursing at the Lutheran Mission Hospital in Chirala. Miss Mabel Meyer, graduate of the Mount Sinai Hospital School of Nursing in New York, is the director of nurses here. The Lutheran Mission Hospital is doing good work, both professionally and spiritually. One of the unique features of the mission program is the service of two Indian women, known as "Bible Women," who sit on the porch floor near the clinic waiting room and play on native string instruments and sing hymns. Patients from the waiting room are attracted by the music and assemble around them. Following the singing of hymns the women tell Bible stories. This service has been one of the more active methods used for the spreading of the Gospel through the work of the mission. This mission hospital is not in a city where modern facilities are available, but the work is well organized and good medical service is given to many.

An unusual sight in this institution was at the back of the hospital under a vine-covered arbor, where the washwomen had the hospital linens spread out on rocks for washing. After applying the soap to the linen they rubbed the linen with their feet by standing on one foot and scrubbing with the other. This made it possible for the women to stand erect and prevent strain on their backs. They looked quite relaxed as they worked.

Medical missions have accomplished much in this great land where the health needs of the people are so acute, although the total medical services are extremely meager. Statistics show that at least half of the nurses educated in India have been trained in mission hospitals.

Another half-day journey brought us to Nuzvid, the location of the 120-bed Giffard Mission Hospital of Seventh-day Adventists and its related accredited school of nursing. This mission hospital is the only successfully operated medical institution in this area. It

is enclosed within a compound surrounded by a high stone wall, and is in a beautiful tropical location which has been very attractively landscaped. Much thought, planning, and prayer have gone into the development of this mission project, and the result is an enviable record today. Miss Emma Binder, graduate of the College of Medical Evangelists School of Nursing in Los Angeles, is the director of nurses.

A weekend trip thirty miles into the jungle with Indian workers to conduct church services in a caste village was another new experience. We spent the night in a hut, the floor and wall of which were cow dung and mud, and the roof, palm leaves. There were no door and no covering on the windows, and animal life could, and did, crawl around in the hut. Oh yes! The name of this village is Chapurivaripalem. They have no shops and no shop signs, no post office, and no road markers, so the length of the village name is not significant. But the hospitality and appreciation of these village folk were proportionately as large as the village name.

It is quite a privilege to be accepted as a guest in a caste village. Next day we accepted the invitation of the people of the village to call at their homes. Each home was a crude hut similar to the one in which we had slept the preceding night. We followed the custom of the village by inquiring about the rice crop, the wellbeing of the children of the home, and the health of all members of the family. Each home we visited had been neatly arranged and carefully swept. In more than half of the homes we found someone sick in bed with a fever, suffering from body sores, or ill from a nutritional deficiency.

WHILE IN NUZVID we were luncheon guests at the home of a rani, wife of a rajah. We learned a good deal during this visit about the customs of the people, especially the wealthy class, and the status of women. Luncheon was served on a porch overlooking a beautiful flower garden. In honor of our hostess we wore saris and found these particularly comfortable when sitting on the floor mat for the luncheon.

A servant passed in front of each guest, serving her a generous amount of rice from a large silver dish. Other servants followed, each with a different kind of curry, such as potato curry, plantain (banana) curry, et cetera. It seems that any kind of food can be used as the base for making a curry. Some were hotter than others, but all were terrifically hot, and I do not mean temperature heat! Knives and forks were not used, as it is customary to mix the curry into the rice with the fingers of the right hand and then eat from the fingers, using the thumb to push the food into the mouth. A good appetite and a little practice soon give alacrity and finesse to this technic. I was not able to read the equivalent of Emily Post for India, but I was told it is considered very poor manners to get food higher than the second knuckle of the right hand. It is also considered uncouth to use the left hand in eating as the left hand is reserved for performing the personal toilet. Although statistics show that gastrointestinal diseases rank high in the causes of death in the Orient, it is quite likely that this custom does help somewhat in the prevention of disease in this great land.

During the rice harvest the homes had intricate maze-like designs marked with chalk powder embellishing the earth in front of the entrances. If an evil spirit should attempt to enter the home it is hoped it would become so entangled in the intricacies of the design that it would be lost and could not find its way into the home.

A baby's eyelids and one eyebrow are often painted with a heavy coating of black mascara as a protection against the entrance of evil spirits into the eyes. They say the reason only one eyebrow is painted is that if the evil spirit starts to enter the eye through one eyebrow it will slide off the other eyebrow and leave the baby's eyes undamaged. No doubt the widespread prevalence of venereal disease, smallpox, trachoma, and other eye infections heightens the parents' desire to protect their baby's eyes. It is to be hoped that these people will be led to a cleaner and safer way of living and a trust in Divine power which frees man from fears and superstition.

Milk is not commonly used throughout the

(Continued on page 414)

Teaching Tactics for Better Teamwork

Health personnel in different divisions work together more effectively when they understand one another's duties and responsibilities.

BEATRICE A. McHARG, R.N.

FOR MANY YEARS newly appointed staff nurses in the Salt Lake City Health Department were given an orientation to the sanitation program as part of the routine in-service education plan. The thought came to us that this was rather onesided and that sanitarians would profit equally from the opportunity to learn about public health nursing. So a cooperative plan was worked out by the director of the sanitation division and the educational director of the public health nursing division for the sanitarians to receive a general introduction to the work of the public health nurses.

Our program objectives were

1. To develop better understanding and teamwork between sanitarians and public health nurses in working toward common goals.

2. To develop insight into the major health problems of the community and to understand the part nurses play in the control of such problems.

3. To increase the sanitarians' appreciation of the importance of ethical relations in all community situations.

4. To stimulate professional growth of both divisions.

We planned a course to cover a six-week period, one two-hour class every Saturday morning. The instruction was carried out by the educational director, supervisors, and staff nurses. Lectures, demonstrations, discussions, field visiting, films, and reports were all utilized. The six periods were centered around the following: (1) the inclusive picture of generalized nursing services (2) school and adult hygiene (3) crippled children services and an explanation of a home visit (4) the nurse in the school hygiene program (5) cancer, tuberculosis, and venereal disease control and (6) communicable disease control. Discussions were to be supplemented by observation visits when possible. Each sanitarian was to observe a home or clinic visit or visit one of the cooperating social service agencies in the community.

At the first meeting the sanitarians were introduced to the members of the nursing staff and were given a general outline of the course. The assistant nursing supervisor gave a fifteen-minute review of the background of the nursing division, the development of the services in the city, and the overall duties of the nursing personnel. Following this staff nurses reported in some detail about the generalized program and about the child health conferences. The men were interested in the child health program and five of them observed at the various centers. At the second meeting they presented reports. The following is a typical one:

"Five minutes limit just isn't long enough to tell about the many things I observed while visiting the Sugarhouse child health conference. They had a full house that day and took care of fifteen babies. Of course these are well baby clinics and the services given are preventive, not curative. It really is an educational program for the mothers.

"The mother carries with her a little baby record book. In this are schedules for the baby and records made by the doctor. When the mother comes in with her baby the nurse examines the book and checks to see if immunizations, et cetera, are due. A good deal of help is given by volunteers from various clubs and women's organizations. These women take temperatures, weigh babies, and help in many other ways.

"Since the service is for well babies the children are examined when they enter the clinic to screen those who may be ill, so that the other children won't be exposed to possible communicable diseases.

"I was most interested to learn that a physician can tell a good deal about a child from measurements of the baby's head and chest. While examining the baby the physician talks to the mother, asking her questions and answering any she may have concerning the child's health and care.

"When the examination is completed the mother sees the nurse again, who summarizes the doctor's findings in the record book and reviews instructions with the mother. When abnormalities are found the children are referred to their private doctors.

"I was also interested in the number of records kept. A lot of the nurse's time is spent on keeping these records. It seems to me these conferences accomplish much good. Often things can be found at an early age which may be hazardous to the child later in years. The nurses have a fine fund of information ready at their fingertips to teach correct nutrition, et cetera. The field trip was very informative and I am happy I had the opportunity to make it."

Subsequent meetings followed the pattern of the first two—preliminary talks by the nurses, field reports by the sanitarians, assignments, and a question and answer period. At the last meeting opinionnaires were distributed. These contained nine questions which the twelve men were asked to answer. The opinionnaires were not signed. The tabulated answers follow:

How did you feel about these meetings? Excellent, 3; good, 7; all right, 2.

What were the strong points? Very good orientation discussions prior to field visits; good organization of visits and projects; good preparation for observations; workable information given; objectives well made; good cases chosen for visiting.

What were the weaknesses in the course? Too much repetition, should be more stringent adherence to time limits for reports; not all the men were able to make field visits; too many reported on same subject; too many speakers scheduled for same sessions; not enough nurses attended the meetings.

Did you understand what we were trying to do? Explain. Most of the men indicated they had understood the plan and cited the objectives to show this. Apparently there was a new awareness of the definite interlocking activities of the various public health community services, and also of the standard of ethics and proper channels of communication and exchange of services. How much this newly-found appreciation of the importance of ethical relations and correct channeling of services will be remembered and used to advantage, only time will tell.

Were you interested in what we were trying to do? Why? Yes, 11; no comment, 1. Reasons were varied but centered mostly on the visits made and the explanations given of the nursing service.

Did reports indicate that those who made them had listened to what others had attempted to teach them? Yes, 9; moderately so, 1; no, 1; no comment, 1.

Was interest maintained or did it lag? Yes, 8; moderately so, 1. Our own thought was that interest was maintained quite well. The younger men were more receptive than the older who tended to be opinionated and not particularly impressed.

How well did the leader serve you? Explain. Three made no comments. The rest indicated that leadership had been effective especially in orientation and in "selling" the public health nursing program.

What improvements would you suggest in the operation of any similar meetings? Arrange for field visits for all the trainees; introduce only information pertinent to the project; limit length of reports; arrange for fuller discussions by trainees. Four persons

had no comments in answer to this question.

This orientation course was an experiment. We think a better job can be done next time. It was the first of its kind tried by our departments. We probably didn't have enough time to prepare properly. Nevertheless, we believe our objectives were accomplished. It seemed to us all the meetings except one were good. In this meeting one of the reporters was so carried away by his enthusiasm he spoke too long. The strongest points were participation in the project by a large number of our staff nurses; high level of teaching carried on; good participation by the sanitarians; achievement of associating names and faces of one's fellow workers; clarification of how we work together; and the sanitarians' enlarged understanding of the scope of public health nursing responsibilities.

In appraising the project we believe the chief weaknesses were the problem of scheduling field visits without resources for following up on these and in general not enough preparation on the part of all the planning group in getting ready for the course. We were unable to stimulate enough interest to have voluntary field visits, so they were assigned arbitrarily, with the result that appointments for field visits were occasionally broken by the sanitarians. There should have been more clarification by the director of the department of sanitation to his employees about what to expect from the course. The sanitarians do not have staff education classes at regular intervals and, possibly for this reason, were not prepared for the intensiveness of the course.

We enjoyed the program thoroughly, both the hard work and the fun. We look forward to incorporating suggestions for improvement in the next classes, as we feel a challenge to repeat the project, for we know the results are worthwhile.

Mrs. McHarg is educational director, Salt Lake City Health Department, Salt Lake City, Utah.

A Visitor in India

(Continued from page 411)

Orient because of its expensiveness and also the scarcity of dairy herds. However, in India the milk of the water buffalo, which has an exceptionally high fat content, is used by foreigners.

Another thing which impresses the traveler in India is the extensive use of human strength in place of machine power. This extends even to street paving. In one village men were pulling a large roller down the street for the purpose of resurfacing. There were probably a hundred men grouped together to pull this roller. They were nude except for loincloths and as they pulled their terrific load the muscles and blood vessels of their bodies stood out like thick cords. To facilitate progress down the road they chanted in unison and pulled in rhythm. Preceding this group were other coolies pouring water from large jars on the paving.

In spite of this display of almost superhuman strength the health status of the people of India is generally poor and they are in great need of better personal and community hygiene, which the nurses of this great country are so earnestly working to bring to all the people.

Miss Burnett is associate secretary for nursing education in the Medical Department of the General Conference of Seventh-day Adventists. She recently spent eight and a half months overseas visiting fifty hospitals and schools of nursing. The latter included the mission hospitals of the Seventh-day Adventist Church and other mission societies as well as tax-supported medical institutions in the countries visited.

Educational Planning by the Public Health Nurse

Lucy C. Perry, R.N.

FACULTY MEMBERS who counsel students in a college or university are sometimes appalled at the complications that arise in evaluating the records of public health nurses who have accumulated credits without having an educational plan or goal. Such students are interested in securing a degree and are greatly disturbed to find that because they failed to seek guidance early they still have many required courses to take, and that they will graduate with an excess number of credits. While these additional courses undoubtedly have value, to the student they often represent a sacrifice of effort, time, and money. Careful educational planning would have prevented this situation from occurring and enabled the student to reach her goal more quickly and economically.

The steps in making and carrying out an educational plan require thought and effort, but will repay the person who undertakes them. These steps are

1. Decide upon a goal to be attained.
2. Select the school in which one wishes to study.
3. Secure and study the bulletin of the school selected.
4. Determine the courses that may be taken prior to admission to the university and correspond with the university concerning the acceptability of courses which may be available either in one's own community or by correspondence.
5. Begin to plan for fulltime study at the university selected.

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The goal

The first step is to decide upon a goal to be attained. The reason for setting a goal is that when a person has a definite aim in life he is more likely to move forward in a straight line than if he has no particular aim. Life can be a succession of goals. When one attains the first goal he sets a higher one and strives for that. This is what gives life meaning and purpose. The person who has something to work toward is a busy happy person who gets a great deal of satisfaction out of living.

The goal the public health nurse decides upon may be to complete the required professional content of a program of study in public health nursing in order to meet recommended qualifications for a public health nursing position as established by the National Organization for Public Health Nursing.

The public health nurse may set a higher goal for herself. She may decide she would like to obtain a bachelor's degree as well as complete her study in the program in public health nursing. Public health nurses realize today that a bachelor's degree not only broadens their outlook through additional courses in the field of general education, but opens the door for advancement in their chosen profession. Many public health nurses have to work toward this goal a little at a

time, but through perseverance are able to achieve it.

Selection of a school

The second step is to select the school in which one wishes to study. The early selection of a school in which to achieve one's goal is important. While the various universities offering programs of study in public health nursing have similarities there are differences in requirements which must be given consideration. The nurse who fails to study the requirements may find that she has made mistakes which result in wasted time and effort. The first consideration is to select a school that is accredited. There are at present thirty-five approved programs of study in public health nursing for graduate nurses. These programs are accredited by the National Nursing Accrediting Service, which took over this function from the National Organization for Public Health Nursing in 1949. This means that these programs meet the essential requirements of the National Organization for Public Health Nursing in theoretical and practical instruction. The approved programs are listed each year in PUBLIC HEALTH NURSING. Each listing includes the name of the person to whom one can write for information regarding the program of study.

Another consideration for the nurse in selecting a school may be the location of the university in relation to her residence. If funds are limited travel to a distant point will add considerably to the cost of education. Approved programs of study in public health nursing are widely distributed throughout the country, but in some areas travel distance to the university is greater than in others and must be taken into consideration when planning.

Review of the bulletin

The third step is to secure and study the bulletin of the school selected. When the nurse writes to the registrar of the university to secure a bulletin describing the program of study in public health nursing, she should be specific as to the program she wishes to follow. Universities publish a number of bulletins for the various schools and departments, and time will be lost if the prospective student fails to indicate the one in which she is interested.

When the bulletin arrives the nurse should study it thoroughly. She should examine its list of faculty and their academic qualifications. She should review the historical background of the program. She should study the admission requirements, fees and expenses, housing accommodations, facilities for field instruction, and above all the requirements for the degree. Under the requirements for the degree will be stated the areas of study and the curricula offered by the university. The curricula in public health nursing will list all required courses in that area. Particular attention should be paid to course descriptions, which tell what prerequisites are required for each course. It is disturbing to the student to find out that she is ineligible for a desired course because she lacks certain prerequisites. Other requirements that should be studied are the total number of credits needed for the degree, the number of credits that must be taken in residence, and when residence requirements must be met. Some universities require that the last thirty credits must be earned in residence; in other universities the requirements may be more liberal.

University bulletins are revised frequently, so that it is well for the nurse to obtain the latest one in order to see if any changes have been made. Changes occur gradually, as a rule, so that there is little difference from year to year. These changes do, however, create problems for students who prolong their college work over many years. Some universities set a time limit within which students must complete degree requirements. Any university may require periodic reevaluation of the student's record.

Parttime study

The fourth step is to determine the courses that may be taken prior to admission to the university, and to correspond with the university concerning the acceptability of courses which may be available in one's own community or by correspondence. It may not be possible for the public health nurse to go away to school immediately. She may be needed in her job, or she may have financial

and other home responsibilities which make it necessary for her to postpone going away to school. This does not mean she has to abandon her educational plan. She should look for a nearby college or university which will enable her to take general education courses required for the degree she would eventually like to earn. If there is no nearby college she might look into the possibility of taking correspondence courses. Most universities will accept a limited number of credits earned by correspondence. The courses taken at home will be useful to the nurse in her work, and will tend to broaden her perspective. Employers usually will assist the interested nurse in arranging her time so that she can take advantage of late afternoon, evening or even Saturday morning classes which may be offered at nearby colleges, universities, or extension centers. The nurse should compare courses and course descriptions of the local institution and the university of her choice to see if they seem to be equivalent. She will find that such courses as English Composition, Literature, Introduction to Sociology, Introduction to Psychology, and History are to be found at many colleges. When the nurse has selected the courses she believes to be equivalent to those at the university of her choice, but is uncertain about whether they will be accepted for transfer, she may clear the matter by writing to the registrar of the university, giving the course number, the title of the course, the number of credits (indicating whether quarter hour or semester hour credits) and the description of the course she wishes to substitute for one at the university. She should keep a carbon copy of her letter and when she receives a reply should file it for future reference in case she should need to verify the approval.

Fulltime study at the university

The fifth step is to begin to plan for fulltime study at the university selected. Parttime study is valuable but there comes a day when most nurses find that they wish to move more rapidly toward their goal or that they are unable to obtain desired courses at home, so they begin to think about fulltime study in the university offering an accredited program of study in public health nursing. The earlier they begin thinking and planning toward this end, the better it will be. One of the requirements will be to save money for expenses at the university. It is true that when a person has some specific goal for which to save money, she is often surprised at the progress she makes. Conversely, when there isn't a plan money seems to melt away.

In addition to saving money the public health nurse can look into the possibility of obtaining a scholarship or stipend. The state department of health in many states has funds available to grant stipends to nurses who wish to enroll in an approved program of study in public health nursing. The nurse may choose her own school, but she usually agrees to work in the state granting the stipend for a specified period after completing her schooling. Information about these stipends can be obtained by writing to the director of the division of public health nursing of the state department of health of the state in which the nurse lives or in which she would like to work. Sometimes other scholarships are available locally.

When the nurse has completed her plans she should write to the registrar of the university for application forms for admission. She should do this well in advance of the enrollment date, as it takes time to assemble credentials. She should not attempt to transfer credits until she receives the official forms of the university and the instructions which accompany them. Many universities require credentials to be filed on special forms, and variation from this procedure would only complicate matters. The university will require high school credits, school of nursing credits, and credits earned at other colleges or universities. When all credentials have been assembled they will be evaluated and the prospective student will be sent a form or letter notifying her that she has been admitted to the university. This form should be filed with other papers pertaining to university attendance. The student will be notified about the number of credits she has on file and the number she will be allowed for her work in the school of nursing. Credits from accredited colleges and universities are transferrable

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Birthday in Cerrillos

SISTER M. ROBERTA, R.N.

"Sister?"

"Yes?"

"Josie is sick, Sister." The voice sounded far away and nervous.

"Oh? What is Josie's last name and where does she live?"

"She is Mrs. Martinez, and we live in Cerrillos near the school."

"Oh yes, Mr. Martinez, I remember Josie. Well now, how is she sick? Is it that the baby's coming?"

"Yes, that's it!"

"When did she start having cramps, Mr. Martinez, and how often are they coming now?" There was a sound of rattling paper as Mr. Martinez unfolded the call slip his wife had given him.

"She says an hour ago, and they are coming every ten minutes now. Her waters aren't broke yet, but she feels real bad. Will you come out now?"

"Yes, Mr. Martinez, I'll be there in about forty-five minutes. You tell Josie to get her bed ready, and you build a fire and put some water on to heat."

"All right, Sister, I'll do that." He sounded relieved as he hung up the receiver.

It took only a few minutes to check Josie's record in the clinic, and copy down the information needed for the "labor notes." Josie had registered at the Catholic Maternity Institute almost five months ago, and since then had come regularly for her examinations. The delivery bag was packed and ready, so I put it into the car and was on my way. Josie's home is almost twenty-six miles from Santa Fe but the road is good and there is little traffic. As I drove, I went over in my mind the information I'd gained from a quick reading of Josie's record. Her baby is due this week, so it won't be premature. Everything was normal on her last clinic visit. She has all her supplies for the delivery ready. It's too bad the new students aren't ready to go on deliveries yet, but they only arrived yesterday. They seem to be a fine group of graduate nurses, all with several years of experience and all wanting to specialize in nurse midwifery. But they'll get plenty of experience during the course. Thank goodness, there was a description of the location of the Martinez home on the record, because in Cerrillos there are no house numbers, no streets with names. But a house with a red roof, about half a mile down the road from the bridge, sounded easy to find.

And it was. Mr. Martinez was at the door waiting. Good, he doesn't look too anxious. "Come on in, Sister." He held the door open.

"Thank you, Mr. Martinez. Hello, Josie! I expected to find you in bed. How are you feeling now?"

"Oh, Sister, as soon as Ramon got back from calling you, my contractions stopped coming. I haven't had one for half an hour. I do hope they start again. I feel so bad that we called you."

"Now don't you worry, Josie. I'll get you ready anyway and we'll see if they don't start again. The contractions do that sometimes and it doesn't mean that there's anything wrong. Come into the bedroom now. Will you lie down while I take your temperature and blood pressure and check the baby's position?"

Josie obeyed smilingly. The examination didn't take long. "Everything is fine with you, my friend. All you need are some contractions! The baby can't come without them, though sometimes we wish he could.

Why don't you get up now and we'll fix the baby's bassinet and get a set of clothes ready for him. Is this supposed to be a boy or a girl?"

"Oh, Sister, whatever God sends will be all right, but Ramon and I would like a boy this time."

"You have two children now, don't you Josie? Are they both girls?"

"No, Sister. One is a boy, but he wants a little brother. And Rosarita wants the baby to be a boy, too."

"Oh, I see. Where are the children now?"

"Over at my mother-in-law's home in Rowe. She'll bring them here tomorrow. My sister-in-law is coming then too, to take care of me and the baby—if the baby decides to come!"

I folded newspapers in a special way to make a receptacle for the waste cotton and gauze. "Josie, I'm so glad your children know that there's going to be a new baby in the family. It's much easier for them when they have been prepared, don't you think?"

"I do, Sister. We talked about it in mothers' class one day at the clinic. I told Junior and Rosarita, and now they can hardly wait for the baby to arrive. I don't think they'll be jealous."

"That's wonderful. You learn a lot at the mothers' classes, don't you?"

"Sister, they help me so much! I'm specially glad I attended the one on labor and delivery, because now I know what will be happening to me when I have those cramps, and I'm not afraid a bit."

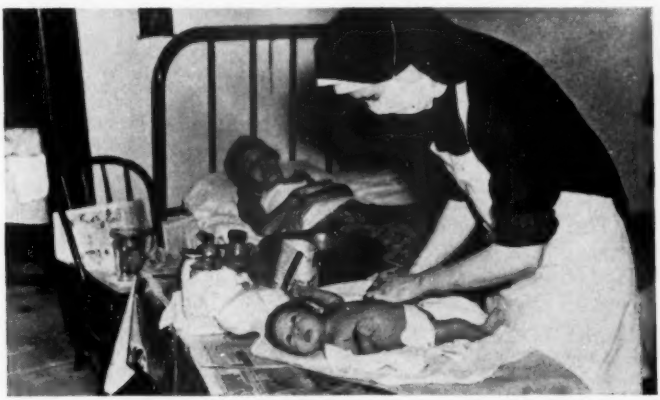
"That's fine! Did you get to the exercise classes too?"

"Only the first one, but the nurse said I learned to relax just perfectly."

"Well, good. You can save yourself a lot of discomfort if you really relax during your contractions. Now if only you would have some!"

Soon all the supplies were prepared. Josie had her mattress well protected with newspaper and two brandnew sheets on the bed. She knew she didn't need new ones as long as they were clean, but a baby's birthday is an occasion! The house had been thoroughly cleaned and the walls freshly calcimined in preparation for the big event. Josie told me she had gotten the blessing for pregnant mothers and had been to confession and Holy Communion just last week. A vigil light was burning before her little image of the infant Jesus, called the "Santo Nino de Atoche." There was nothing to do but pray and wait. It was an effective combination, for in a little while the real thing began.

Josie was a little frightened now. "They start in my back, Sister, and they last so long!"



"Well, that's a good sign. Contractions like that really do the job. Now, Josie, let's see how you can relax with this one. That's right! Doesn't it feel better when you do that?"

"Yes, Sister, it sure does. I guess I forgot about that."

"I'll sit right here by your bed and help you relax. I'll rub your back, too, if you like."

Ramon came in to join in the waiting and we prayed together for a happy delivery for Josie. As the contractions interrupted, Josie gave all her attention to doing the abdominal breathing exercises she had learned.

After some time the contractions became stronger and closer together, and I gave her a little capsule of medicine. "It won't stop the cramps, but it will help you to sleep a little and make it easier for you to relax." Josie took it gratefully and sat up for a glass of milk and some cookies. "That's fuel for the engine, so you'll have something to work on when the labor begins."

"I remember about that, Sister. I'll have to work to push the baby out when the mouth of the womb is all the way open."

"That's right, Josie. I'll tell you when it's time for that. It'll be a while yet."

The medicine took effect before long and Josie napped between contractions. I took out a little book for just such occasions and read while Josie slept. Ramon tiptoed in to see that everything was all right. Reassured that it was, he asked if he could leave for a while. "Why surely, if you won't be too long. I'll need you to be my first assistant in a couple of hours."

"I'll be only ten minutes, Sister."

In a little while Ramon returned with a brown grocery bag in his hand. Soon the good odor of coffee filled the little adobe house. "Sister, you haven't had your dinner yet. Won't you come and eat?"

"I'd love to. That was very thoughtful of you. Will you come and sit by Josie?"

The kitchen table was all set. Ramon Martinez had fixed his idea of a feast: coffee, a stack of buttered fresh toast, and four cream puffs. It might not be a balanced meal, but it surely looked good. I sat down and enjoyed it immensely.

When I had finished, Josie was wide awake. "Sister, they're much harder now and coming real often."

"I'll examine you again and see how things are." The findings were encouraging. "Josie, you're almost fully dilated. It won't be long now!"

The last-minute preparations were made. Sterile drape sheets, instruments, and gloves were brought from the delivery bag, boiled cotton brought from the kitchen, the baby oil set on top of the stove to warm. Ergotrate was drawn up into the hypodermic syringe, ready to give.

"All right, Mr. Martinez, now you must help me while I scrub my hands. It will take five minutes, so have a good supply of warm water ready." There was no sink, no running water, but Mr. Martinez with a pitcher was as good as any knee-control faucet, and the dishpan made a fine sink. While I scrubbed hands and arms with soap and brush, I encouraged Josie to continue to relax although she was getting a little tense with excitement.

"Sister, I'd be so frightened if you weren't here now."

"Of course you would, but everything is just fine, so don't you worry." Sterile gloves and apron on, I draped the patient, who was already feeling a strong urge to bear down with her contractions. "All right, Josie, the time for relaxing is over. Get a good deep breath when you feel the contraction coming, hold it—and push."

"Oh, Sister, it feels so good to be able to push."

"Fine. Would you like your husband to be here when the baby is born?"

"Yes! Can he?"

"Mr. Martinez, would you like to come in now? You can sit near Josie's head and hold her hands under the sheets." Ramon was there in a twinkling.

"Another little push, Josie. All right! Now stop pushing and pant. Good, good! And here he is!" The baby's nose and mouth were wiped quickly with sterile gauze. Then his first welcome cry was heard. Josie was up on her elbow.

"Oh, let me see him, let me see him! Ramon, it's a boy, isn't that wonderful!

Thanks to God, thanks to God. Is he all right, Sister?"

"Yes, Josie, he looks just perfect. He's a fine boy. You can both be proud of him. And you surely were good, too."

When the baby's cord was cut and tied, he was carefully deposited in Ramon's arms who then sat by the stove cradling him as instructed. Keeping a watchful eye on the baby, Josie and I waited for the afterbirth to come. It didn't take long. Then the medicine to prevent too much bleeding was injected into Josie's arm. She winced but the pain reminded her of something she had been too busy to say a while ago. "Sister, it wasn't bad at all, having the baby! I couldn't remember very much about having Junior and Rosarita, but I knew it was an ordeal and I dreaded this labor. I guess I was a little scared after all."

"Well, that's not surprising. Turn over now, so I can slip a clean newspaper pad under you. Labor means hard work, the hardest work a woman has to do. But if you understand what's happening to your body and how to cooperate with it, then you can help. It's work because it takes attention and effort but you have the satisfaction of a job well done as well as the reward of knowing you've given your baby the safest possible start in life. You didn't have much pain, did you?"

"No, Sister." Josie was thoughtful. "The contractions I had while you were scrubbing your hands were the worst, but as soon as I could push, it didn't hurt any more. And it was wonderful to hear my baby's first cry and see him right away. I'm going to have all my babies this way, from now on!"

"Well, for goodness sake, don't be thinking about having any more tonight! What you need now is a big meal and a good night's rest. What would you like to eat?"

"Oh, I am hungry. What could I have?"

"Whatever you want, from steak and potatoes on down. You decide and tell your husband and he'll fix it. Now I think you ought to hold the baby. Ramon's been having all the fun long enough." Ramon smiled and relinquished his son to Josie.

Writing up the notes on the delivery, I could hear Ramon and Josie softly exclaiming together over the baby. "He has so much hair, Ray! Looks just like you. I can hardly wait till the kids see him." Then Ramon was in the kitchen whistling as he rattled pots and pans. He stuck his head into the bedroom. "Will you eat something, Sister?"

"No, thank you, Mr. Martinez. But fix enough for yourself and you can eat in here with Josie."

He grinned. "I sure am hungry, Sister. I feel like I've been working, too."

It didn't take long to get the baby cleaned and weighed and dressed in his brandnew clothes. "He's a beautiful baby, Josie. I'm going to put his bassinet on the table beside your bed, so you can peek at him every now and then. He'll probably be quiet tonight, because he's ready for a rest just like you are."

With my delivery bag all repacked, I was ready to leave. Ramon came in from his cooking. With a proud flourish he handed me several bills. "Ten, twenty, twenty-five."

"But Mr. Martinez, Josie has already paid five dollars. The fee for her maternity care is twenty-five dollars and this makes thirty."

He waved away all objections. "That's all right, Sister. We want you to have it. Wish it could be a hundred and thirty."

"Well, thank you, Mr. Martinez. We're always happy to receive donations. It's expensive to run our maternity service with all the travel involved. But I don't think we'll ever charge a hundred and thirty. We try to keep our fee as small as possible because we are convinced that every mother is entitled to have good care at a price she can pay. That's one of the reasons that there is a Catholic Maternity Institute in Santa Fe."

"God bless you and reward you, Sister. When will you be back?"

"One of us will be in to see Josie and the baby tomorrow and every few days for the next two weeks. Whenever you need us, though, be sure to call, no matter when it is. Everything seems to be fine with them so far. I don't think there will be any trouble. Goodbye, Mr. Martinez. Thank you so much for your help. Goodbye, Josie, you certainly were

a good patient. It was a real pleasure to be here with you. Good night."

"Thank you again, Sister. Good night!"

The Catholic Maternity Institute in Santa Fe, New Mexico, was opened in 1945 by the Medical Mission Sisters of Philadelphia. At that time infant mortality rate in New Mexico was higher than in any other single spot in the country. To relieve this situation the Sisters set up their nurse midwifery service which enables the poor of this region to have the benefits of competent care before, during, and after the birth of a child. Since its beginning over 1700 babies have been delivered in the poor adobe homes. A school of nurse midwifery was established in connection with the CMI. Here registered nurses are trained to become certified nurse midwives. The school is affiliated with the Catholic University of America in Washington, D. C.

Sister M. Roberta of the Medical Mission Sisters is a graduate of St. Edward's Mercy Hospital in Fort Smith, Arkansas, and holds a B.S. degree in nursing from St. Louis University. Since January 1949 Sister M. Roberta has been on the teaching staff of the Catholic Maternity Institute in Santa Fe.

Educational Planning

(Continued from page 417)

but there may be certain restrictions. For example, many universities do not accept credits from other universities if the grade for the course was D and all credits accepted are not necessarily applied toward a degree.

When the nurse has enrolled on campus she will have opportunity for further counseling and guidance in planning her program so that she will be able to qualify for a degree. Students often ask questions in regard to having credit granted by the university for experience or for courses taken under other auspices than those of an accredited university or college. Universities are unable to grant credit for experience which was not acquired under university direction or in agencies approved for field instruction by the university. In certain instances the requirement for field instruction may be waived. Universities are unable to grant credit for a course offered by a local club or organization unless that course was taught under the auspices of an accredited college or university which kept a record of it on file in the office of the registrar. Universities are unable to alter credits granted by other universities or colleges, but allow the same number of credits for the course that was granted by the university where it was taken. Universities transpose quarter-hour credits into semester-hour credits, and vice versa, according to a formula that has been devised.

Many nurses today are working toward an educational goal. Every year a number of them achieve that goal. Some have reached it through trial and error. Others have been saved from making mistakes by the advice of those who have gone before them. It is hoped that these suggested steps for educational planning will encourage still more nurses to attain the satisfaction derived from a broad general education and better professional preparation for public health nursing.

Integration of Physical Therapy in a Generalized Public Health Nursing Program

A report of the physical therapy service in the State of New York Department of Health

MARIAN H. PRATT, R.N., P.T.

IN NEW YORK THE state physical therapy services have been expanded and integrated into the total public health nursing program under a new plan. This involved broad changes in organization and procedure as well as staff education, and was undertaken in response to increasing demands for physical therapy services in both the orthopedic and general nursing programs. It has resulted in better patient care, wider recognition of conditions needing physical therapy, and greater acceptance of the program.

The new plan was launched in 1944 with broad changes in the state setup. The Bureau of Medical Rehabilitation was largely reorganized under the Division of Medical Services in the State Department of Health, and the work formerly done by the Division of Orthopedics incorporated into it. Thus the program of the Division of Orthopedics, formerly specialized, was made part of the generalized program in the field. Changes were made in job titles and requirements and in nurse assignments. Orthopedic patients under care were classified to assist the nursing staff in determining their needs. Staff training in physical therapy was provided.

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At the time of the reorganization the orthopedic nurses had had a minimum of four months specialized training in orthopedics; not all were physical therapists. Plans were made to release these nurses as soon as possible for physical therapy courses. All future appointees will be physical therapists.

A group of the orthopedic nursing staff were given the title of assistant supervising nurse (orthopedics) and assigned to serve as supervising physical therapists. It is expected that under a civil service reclassification this title, which is unsatisfactory and undesirable, will be changed to supervising physical therapist, and the title orthopedic nurse to physical therapist.

Earlier the orthopedic nurses had been directly responsible to the administrators of the Division of Orthopedics in central office and in theory to the local health officers. As a matter of fact, they had administered most of the program locally. Under the new plan responsibility for the local administration of the program was transferred to the fulltime local health officers and the supervising nurses were made responsible for the nursing aspects of the program. The supervising nurse (orthopedics) and the orthopedic nurses were assigned to work under the direction of the health officer and the supervising nurses in their respective areas.

Nurse responsibility outlined

Under the old plan the orthopedic nurses had been burdened with many functions not related to actual patient care. An analysis was made of the functions of the health officers, nurses, and clerical staff, and specific responsibilities were worked out. The duties of the nurses were outlined as follows:

Under the general direction of the health officer the supervising nurse will be responsible for the supervision of all nursing service given at home or in clinics, including service to patients with orthopedic and nonorthopedic conditions which fall within the scope of the program.

Under the direction of the supervising nurse the assistant supervising nurse (orthopedics) will be responsible for the supervision of the technical aspects of orthopedic nursing and physical therapy care.

The generalized public health nurse will be responsible for all nursing service to the family and individual, either in the home or in clinic, with such assistance and supervision from the assistant supervising nurse (orthopedics) in orthopedic nursing and physical therapy as indicated.

The responsibilities of the supervising nurse and assistant supervising nurse (orthopedics) were outlined in detail as follows:

Supervising Nurse

1. General supervision of all services provided at home or in clinic.
   a. Assignment of all medical rehabilitation cases to public health nursing service.
   b. Assignment of duties to all nursing and lay personnel at orthopedic clinics.
2. Development of the nursing service in relation to the whole program.
   a. Interpretation of medical rehabilitation policies and procedures to all nursing staff.
   b. Development of staff education in relation to the whole program.
   c. Evaluation of nursing service in general in the whole program.
3. Interpretation to community and cooperating agencies of nursing service available in the medical rehabilitation program.
4. Establishment of working relationships and agreements with local agencies, fulltime county health units, and city departments of health in regard to medical rehabilitation nursing service.

Assistant Supervising Nurse (Orthopedics)

1. Demonstration of physical therapy technics and supervision of both generalized nurses and physical therapists in relation to physical therapy procedures. Supplementing physical therapy given by the generalized public health nurse to patients requiring such services. Physical therapy to patients requiring specialized service in areas where there is no local public health nurse. Knowledge of status of all patients on active service who require physical therapy.
   a. Responsibility for classifying all patients requiring physical therapy service according to method adopted, and assisting the supervising nurses in assignments.
   b. Teaching and supervising technical physical therapy service at clinics.
2. Assistance in developing the physical therapy aspects of the service. No responsibility for other than physical therapy aspects except as assigned.*
   a. Assistance to the supervising nurse in interpretation of policies and procedures to the nursing staff in relation to the physical therapy aspects of the program.
   b. Assistance to supervising nurse in staff education to relate physical therapy to nursing, to improve care, to promote case-finding, and to apply preventive measures.
   c. Provision of information as required by the supervising nurse in evaluating the physical therapy service and the service of the general public health nurse in relation to the physical therapy care.
3. Assistance to the supervising nurse in interpreting to the community and cooperating agencies the physical therapy services available.
4. Assistance to supervising nurse in estab-

* Plastic conditions, such as those resulting from burns, involving muscles and joints should be considered the supervisory responsibility of the assistant supervising nurse (orthopedics).

lishing working relationships and agreements with local agencies, fulltime county health units, and city departments of health in regard to physical therapy service.

Classification of cases

The first step taken under the new setup was to classify all the active orthopedic cases in the medical rehabilitation program under four classifications according to nursing and physical therapy requirements. The purpose was to assist the nursing personnel in determining the nursing and physical therapy needs of the patients. The classifying was done by the supervising nurse, assisted by the assistant supervising nurse (orthopedics). It was understood that these classifications were not static but would change from time to time in accordance with a physician's recommendations. The four classifications were outlined as follows:

Classification I

Includes patients requiring physical therapy which can be given only by the physical therapist as a supplement to the service of the generalized public health nurse.

Examples:

1. Muscle reeducation to patients in acute and early convalescent stages of poliomyelitis, peripheral nerve injuries, or reconstructive surgery.
2. Stretching involving the joint capsule.
3. Complicated fractures.

Classification II

Includes patients who require selected physical therapy procedures that may be given by the generalized public health nurse with demonstrations and supervision by the assistant supervising nurse (orthopedics).

Examples:

1. Progressive relaxation.
2. Muscle stretching where there is no shortening of the joint capsule.
3. Crutch walking.
4. Physiological bed positions for the chronically ill patient.
5. Some corrective exercises.
6. Inspection of braces for fitting and condition.
7. Periodic checking of height and chest expansion in standing and sitting positions of patients with scoliosis.

Classification III

Includes patients who require general health teaching or nursing care and do not require the services of a physical therapist. This service is supervised by the general supervising nurses.

Examples:

1. Rachitic bowlegs.
2. Delayed physical development.
3. Congenital deformities not requiring remedial work at this time.
4. Patients awaiting hospitalization after all arrangements are completed.
5. Quiescent bone or joint infections with possibility of recurrence.

Classification IV

Includes patients who do not require nursing or physical therapy care and who are to return to clinic for examination.

Examples:

Patients who have reached maximum recovery but still require periodic examination at clinic for checking growth and development, and adjustment of braces, shoes, and artificial limbs.

The assistant supervising nurse (orthopedics) or the physical therapist under the direction of the supervising nurse is responsible for the technical care of all cases in classifications I and II. The general supervising nurse, in consultation with the physical therapy staff, is directly responsible for the supervision of cases in classifications III and IV.

Staff education

Extensive staff educaticn on the principles and practice of physical therapy was provided. During the period of transition in program, institutes were given to the group of assistant supervising nurses (orthopedics) in supervisory methods. A series of regional institutes were conducted for all the orthopedic nurses by the consultant nurses in physical therapy, who were responsible for the technical supervision of the orthopedic nurses and physical therapists.

Demonstrations were given, technics and various methods of teaching were reviewed and demonstrated, and practice periods provided for the staff. Local staff education programs were given for the generalized public health nurses. Principles were stressed rather than individual technics. It was believed that for better results individual technics should be demonstrated as applied in a specific situation.

In spite of these local staff education programs the general supervising nurses thought they still had much to learn about what was involved in the care of the orthopedic patient if they were to be adequately prepared for the administration of this nursing care. Therefore, a series of two-week institutes were held at the New York State Rehabilitation Hospital at West Haverstraw for the general supervising nurses. The objective was to give these nurses an appreciation of the principles of orthopedic nursing and physical therapy so that there would be better correlation of hospital and home care and so that guidance to both the nursing and physical therapy staffs would be given with more understanding. The group included nursing supervisors from state, county, and city departments, and from visiting nurse associations.

These nurses were given an orientation in the needs of patients falling within the scope of the medical rehabilitation program. Emphasis was placed on the home follow-up of these patients. It was the consensus that the institutes were a decisive factor in the eventual success of the program. The following will give a general idea of the program:

First Week

Monday	Orientation to hospital	Hospital director
	Pretest and review of terminology	Consultant nurses in physical therapy
	Principles of posture and body mechanics	Consultant nurses in physical therapy
	Observation of normal infant	Generalized supervising nurse
	Possible deviation from normal (infant)	Consultant nurse in physical therapy
	Nutritional factors	State nutritionist
Tuesday	Ward rounds—Juvenile Building	
	Normal development in preschool and school-age child	Generalized public health supervising nurse
	Possible deviations from normal	Consultant nurse in physical therapy
	Fundamentals of orthopedics, including poliomyelitis	Orthopedic resident
	Nursing care—packs, positioning, respirator	Hospital staff nurses
Wednesday	Consultation rounds	All attend consultation rounds
	Ward rounds	
	Group A	Split into two groups for ward rounds
	Group B	
	Physical medicine	Lecture by physical medicine consultant
	Physical medicine rounds	
Thursday	Ward rounds—Women's Building	
	Physical therapy and poliomyelitis	Director of Physical Therapy Department
	Bones and joints	Lecture by orthopedic resident
	Relationship between nursing and rehabilitation	Director of Rehabilitation Department
	Scoliosis	Lecture by orthopedic resident
	Nursing care of cast patients	Demonstration by hospital nurses
Friday	Ward rounds—Men's Building	
	Exercises and stretching	Director of Physical Therapy Department
	Psychology of the handicapped	Hospital staff psychologist
	Congenital anomalies, including nutritional	Lecture by orthopedic resident
	The value of occupational therapy in handicapping conditions	Director of Occupational Therapy Department

Second Week

Monday	Ward rounds—Juvenile Building	
	Ward evaluation and nursing demonstration	Hospital staff nurses
	Fractures and dislocations including transverse myelitis	Lecture by orthopedic resident
	Observation of cerebral palsy unit	
Tuesday	Ward rounds—Women's Building	
	Group A—Plaster room	
	Group B—Physical Therapy Department	
	Speech therapy	Speech teacher
	Cerebral palsy	Lecture by orthopedic resident
	Nursing care in cerebral palsy	Hospital nurses
	Group A—Physical Therapy Department	
	Group B—Plaster room	
Wednesday	Grand rounds	
	Ward rounds	
	Group A	
	Group B	
	Cerebral palsy conference (Biweekly meeting of representatives of each department)	
	Physical medicine rounds	
Thursday	Ward rounds—Men's Building	
	Genitourinary conditions in transverse myelitis—indications for plastic work	Genitourinary medical consultant
	Nursing care and equipment in genitourinary conditions	Hospital staff nurses
	School	Principal of hospital school
	Arthritis including Still's disease	Lecture by orthopedic resident
	Brace equipment	Hospital bracemaker
	Care of braces	Consultant public health nurse in physical therapy
	Group A—Observation of cerebral palsied in Occupational Therapy Department	
	Group B—Rehabilitation Department	
Friday	Group A—Rehabilitation Department	
	Group B—Observation of cerebral palsied in Occupational Therapy Department	
	Progressive relaxation	Consultant public health nurse in physical therapy
	Flat feet	Lecture by orthopedic resident
	Emotional aspects of the handicapped	Consultant public health nurse in mental hygiene
	Posttest	
	Evaluation conference	

Expansion

As the program expanded implications for the use of physical therapy in all phases of nursing care became apparent. The title of public health nursing consultant (orthopedics) was changed to public health nursing consultant (physical therapy). The new title embraces a much broader concept in function than the old one. It means the consultants act in a technical advisory capacity and have no administrative responsibility. They share technical knowledge in their specialty with the public health nursing and physical therapy staffs. The consultants correlate all nursing

activities in their field with the nursing program throughout the state. The job was one of promoting, instructing, and supervising in the specialized field. Since the reorganization the bulk of the consultant's time has been spent in supervising the technical skills of the physical therapist; advising field personnel in regional and district offices and fulltime county and city health departments on technical problems of physical therapy and application of the principles of posture and body mechanics in nursing; advising and assisting field personnel on coordination of all available physical therapy service, public and private; and assisting in the preparation and conduct of inservice training programs.

All of the orthopedic nurses who served under the earlier program have now had courses in physical therapy. Because of the dearth of physical therapists with public health nursing background it was necessary to try a new venture in order to include enough people to do a good job. Several physical therapists without nursing background were added to the staff. They were given a well planned orientation in the overall public health program. Such an orientation, although it involved a great deal of time and thought on the part of the local personnel, paid dividends in the quality of service eventually rendered. Since she was familiar with the functions of the various workers the physical therapist was aware of the part her own specialty played in the program. There is evidence that the physical therapist without a public health nursing background has a real contribution to make in a public health program.

The physical therapy staff are now devoting their time to the practice of their specialty. This consists of direct service to patients, teaching and supervising the general staff nurses in the technical aspects of patient care, and assisting in staff education programs. In these ways both the quality and quantity of care have improved.

Other factors contributing to the progress of the program have been

1. *The development of physical therapy centers in local areas.* Wherever it is expedient patients go by appointment to a central place, where they are treated by the physical therapist or the public health nurse under the technical supervision of the physical therapist. Parents are urged to attend with their children so that they can be taught to give the interim treatment or can be supervised in doing what has previously been taught. These centers cut down considerably on staff travel time and help in developing in the families a sense of responsibility and independence.

2. *The development of physical therapy prescription forms for use in the program.* These prescription forms must be filled out and signed by the physician ordering the treatment. The various modalities are itemized, the purpose of treatment is stated, and contraindications and other pertinent data are listed. These prescription forms were developed because the increased use of physical therapy in the care of patients intensified the necessity for more concise and clearly defined orders for treatment.

3. *The trend toward the use of physical therapy in many conditions other than orthopedics.* Nurses are recognizing situations and conditions where assistance from the physical therapist is needed. Bed-positioning in long-term illness, rehabilitative work in the field of geriatrics, postoperative conditions such as radical mastectomy, and positioning in burn cases, are a few examples of cases arising in general nursing which require the services of the physical therapist.

4. *A great increase in consultation orthopedic clinics for local physicians.* Local physicians have the privilege of referring patients to clinics for consultation or for consultation and treatment. The recommendations of the clinician are sent to the private physician within a few days. No physical therapy treatment is given without his approval. The supervising nurse is in charge of the clinic. Public health nurses assigned by her assist the clinician. The supervising nurse arranges for the patient to see the physical therapist at the clinic when indicated. The physical therapist does muscle gradings and demonstrates physical therapy on patients as ordered in a room set up for this purpose.

Summary

The physical therapy services have gone a long way toward generalization in the total public health nursing program since the reorganization. The greatest difficulty was encountered in laying the actual groundwork and in setting up procedures. Once this was accomplished the broad educational needs had to be met. These included not only the preparation of the former orthopedic nurses in physical therapy, but getting the whole concept across to the medical, nursing, and clerical staffs. One great bottleneck was the shortage of trained personnel. One of the answers has been using physical therapists without public health nursing background. There is definite evidence of acceptance of the program in the numbers of referrals to clinics and nursing service by physicians. Nurses are recognizing conditions needing care and referring them for medical care. There is a growing demand for physical therapy service in an ever-widening field.

The combination of physical therapy plus good nursing care by staff members qualified in their respective fields and working as a team has resulted in improved care for patients. One might safely conjecture that this type of program may provide the means for the expansion of this type of service in the public health field.

ABOUT PEOPLE YOU KNOW

One of the highest honors of the International Committee of the Red Cross, the Florence Nightingale Medal, was awarded to *Colonel Florence A. Blanchfield* and *Sophie Nelson*. The medal was originated in 1912 and Colonel Blanchfield and Miss Nelson are the twentieth and twenty-first Americans to receive it. Both recipients have been active in Red Cross circles for many years. . . .Representative *Frances Payne Bolton* of Ohio was awarded the Adelaide Nutting award at the fifty-fifth convention of the NLNE in May. Mrs. Bolton is a member of the Advisory Council, NOPHN.

In June *Sally Lucas Jean* retired as health consultant and director of educational services, NFIP. Miss Jean entered the public health field as a school nurse in Baltimore in 1910. Since then she has been associated with outstanding organizations and has served as consultant in health education to many programs. Her goal has always been to help children achieve better health practices. Miss Jean has received many honors and awards. She has been a frequent contributor to this magazine.

Anna Heisler, who retired in December 1950 from the USPHS, will be acting director of the Alaska Department of Health while *Dorothy K. Whitney*, the director, is on educational leave. Miss Heisler's new appointment takes effect August 15, 1951. Her headquarters will be in Juneau. . . . *Harriet F. Young* retired in July as director of the Wyoming Valley VNA. Miss Young will be greatly missed in Wyoming Valley. She is succeeded by *Hannah E. Dutter*, who has been assistant director.

Lucile Petry, chief nurse officer, USPHS, was given the honorary degree of doctor of science by Boston University in June. . . . *Ruth C. Adams* is the educational director in the Division of Public Health Nursing, Vermont Department of Health. . . . *Janet Walker*, associate professor, University of California, Los Angeles, will be attached to the National Nursing Accrediting Service during the summer. Miss Walker will summarize annual reports of programs in public health nursing designed to prepare nurses for beginning positions in the field. She will return to give the reports to the Public Health Board of Review, NNAS, at the annual meeting in November 1951.

The National Foundation for Infantile Paralysis announces the appointment of *Raymond H. Barrows* as executive director of the foundation. Mr. Barrows, formerly vice-president and manager of the Pacific Area of the ARC, succeeds *Joe W. Savage*, who is joining King Features Syndicate. . . . *William Vogt* is the newly appointed national director of the Planned Parenthood Federation of America.

WORKING TOGETHER

An experience in relationships with fulltime and parttime faculty

ESSIE ANGLUM, R.N.

THE OPPORTUNITY TO examine in an introspective manner our ways of working together has served to focus our attention on features often taken for granted. Yet in the analysis of these features it is apparent that the relationships upon which our planning is based are fundamentally the all-important element that serves to keep the group a closely coordinated unit. The methods employed in helping a faculty composed of several parttime members to function smoothly are effective because of this understanding of the importance of relationships.

Because the Loyola University School of Nursing is situated in an area rich in teaching resources the selection of a parttime instructor for his authoritative knowledge, experience, and accomplishment in a specialized field is an easy task. Let us follow the steps that bring this expert into the Department of Public Health Nursing as a faculty member. Over a period of ten years a file, a real treasure chest, has been compiled containing the "Who's Who" of all who have participated in the program. This is kept up to date and serves as a constant resource. If the specialist selected cannot accept an assignment for a given semester he is always ready and willing to recommend someone in his particular field who is equally expert.

Once the tentative selection of the potential parttime faculty member has been made the general and the specific objectives of the program are reviewed. During succeeding interviews the total curriculum is discussed, with emphasis on the relationship of the proposed course to the total program.

Identical application forms are used for both fulltime and parttime applicants, but the parttime member is given no formal contract of employment. A letter from the dean verifying the appointment serves this purpose as effectively as any legal agreement.

The title of lecturer is given to those who serve on a temporary or parttime basis. Normally such a person is fully qualified to be given rank within the university, but appointment as lecturer has no reference to the university tenure. However, the voluntary long-term tenure of the parttime faculty is one of the real indications of the satisfaction with this policy.

The following statements selected from a list compiled by the parttime faculty reveal positive attitudes relating to such appointments:

1. The opportunity is offered through a teaching appointment to give to others the benefit of one's experience and observation in a particular field.

2. One cannot teach a subject well without coming to know the subject more thoroughly. This is a real source of personal satisfaction.

3. Recognition by students, fellow faculty members, and contemporary colleges and universities offers an opportunity to improve one's professional status.

4. The opportunity is given to become a member of the university family with its distinct social and professional life.

After appointment, faculty meetings offer the best avenue to help the parttime faculty member appreciate the place of his specialty in the curriculum plan. At the general staff meetings held routinely each semester, course outlines are reviewed and proposed changes are discussed. Ideas are exchanged and examined, which aid in the constant effort to attain better integration. Recommendations growing out of these discussions are presented

to the Executive Committee of the School of Nursing for approval, and then are acted upon. The small committees working between the regular meetings are not only an important medium for the improvement of course content, but also furnish opportunity for mutual cooperation.

One of the recent recommendations of a parttime faculty member has resulted in the planning of a seminar meeting each semester. The purpose is to afford a wider opportunity to hear from fellow faculty members of advancements, trends, and reports of studies relating to the various specialties.

THE VALUE OF COMMITTEES cannot be overestimated when discussing methods of improving relationships that serve to strengthen the educational program. It seems that the influence and importance of these committees are even greater when the fulltime faculty is in the minority. Formation of committees for study of problems relating directly to the curriculum is the responsibility of the fulltime faculty. Such committees are created, remain active, and are terminated as the needs are shown in total curriculum planning. The result of their energy and creativeness depends not only upon the vision of the fulltime faculty, but equally upon the sound interpersonal relationships that exist within the entire faculty.

The Field Advisory Committee furnishes a typical example. The chairmanship is carried by a fulltime faculty member, but subcommittee chairmen are selected from the field advisory group. They in turn solicit the service of others who represent the many facets of public health nursing. A special committee served in reviewing the various contributions submitted by the parttime faculty members as part of the preparation for this article. At a meeting called to discuss its preparation the group recommended that a committee of three volunteers be responsible. The material reviewed revealed that the following points were emphasized by the majority of the parttime faculty group:

1. The parttime member is often in a position to evaluate the outcomes of teaching through observation of actual field application when the nurse becomes a staff member of the agency in which the instructor is employed.

2. Because the parttime faculty member is engaged in professional activity on the "firing line" he or she brings to the class meetings a timely and vital presentation of changes and trends in the field of specialization.

3. Membership on a wide variety of professional committees brings a vital understanding of current public health problems, which is reflected in the guidance of classroom discussions.

As an illustration of the third point, during one week last May members of our parttime faculty were present at meetings in New York, Baltimore, Boston, Minneapolis, and San Francisco, at the International Congress of Gynecology and Obstetrics, the Society of American Bacteriologists, the Massachusetts State Medical Society, at a workshop at the University of Minnesota, and at the biennial convention of the ANA, NLNE, and NOPHN.

Representation by both groups on committees of the American Nurses' Association, the National Organization for Public Health Nursing, and the National League of Nursing Education serves a two-fold purpose in contributing to the constant upgrading of professional standards and in keeping students informed of and alert to opportunities for individual service.

Membership on program committees offers all faculty members an equal opportunity to promote effectively the educational program. Only to emphasize this ever-present and richly rewarding area do I mention these instances, representative of the way all faculties are sharing in helping educational programs play a realistic role in both professional and community organizations. At present faculty members are assisting in program committees through these methods:

1. Aiding in the selection of topics and speakers for meetings.

2. Aiding in planning both content and methods of conducting these programs.

3. Serving as participants in programs as speakers, panel moderators, and as resource persons.

What is the responsibility of the fulltime faculty in relation to curriculum planning,

and how is this shared? The general plan of course offerings in any given semester and the pattern followed in the academic year are determined by the fulltime faculty, but not without due consideration of recommendations made by the parttime faculty. The scheduling of late afternoon and evening classes has been a reflection of the local need. The ultimate decision regarding the continuation of this pattern rests with the fulltime faculty, but again parttime faculty recommendations carry weight.

THE STIMULATION OF student interest and enthusiasm is a shared responsibility. We believe, of course, that the student in turn shares this interest with others in the school and in the community. A request originating with the parttime faculty for the continued use of a teacher-appraisal scale demonstrates acceptance of responsibility in stimulating this interest. This instrument had been used on an experimental basis in a previous semester. During a recent faculty meeting two of the parttime instructors who had reviewed their results, and discussed them with the counselor, described the personal benefit they felt had been gained from even one student evaluation of their classroom methods. The group recommended that the use of the form be resumed. Since that meeting all of us have had the benefit of receiving a personal mirror in which to glimpse a reflection of our teaching.

An administrative responsibility belonging to the fulltime faculty is the constant awareness of the need to have our program become better known to other departments within the university. The development of closer working relationships with other departments through course planning serves a dual purpose in this respect. As an example, a course listed in the Department of Psychology, Dynamics of Learning, a prerequisite to the course in the professional program, Methods of Community Teaching, was developed through interdepartmental planning and has resulted in more productive relationships for all concerned.

A review of these aspects of the program would be lacking without mention of the stimulation that is constantly experienced in a faculty weighted with parttime members. There is an appreciation that something vital would be lost without the spark brought by the experts, and there is a realization on their part of the stability brought by those on a fulltime basis.

The mutual understanding and appreciation of the contribution made by each to the total development of the program are perhaps best evidenced by the desire of the group to share. A strong feeling of unity has grown from the beginning and is a constant source of satisfaction. The program would be poorer if the parttime faculty gave anything less than fulltime interest to the program. The fostering of this interest remains with the fulltime faculty, not only those members in the Department of Public Health Nursing, but the entire School of Nursing.

Miss Anglum is chairman, Department of Public Health Nursing, Loyola University, Chicago.

Enrollments of Students

TWICE A YEAR the NOPHN collects and analyzes data on enrollments of students in educational programs approved for public health nursing.* The information for the 1951 spring enrollment period has just been studied. Thirty-eight colleges and universities reported a total of 4,052 students: 3,329 graduate nurse students and 723 students in collegiate basic programs.

GRADUATE NURSE PROGRAMS

Thirty of the thirty-five colleges and universities reporting on graduate nurse students had submitted data in 1950. Therefore it was possible to compare spring enrollments of the two years. These thirty institutions reported a drop of 425 students. See table for the figures for fulltime and parttime students.

	Spring 1950	Spring 1951	Decrease in Enrollment
Total	3,460	3,035	425
Fulltime	1,354	1,141	213
Parttime	2,106	1,894	212

In the thirty-five colleges and universities there were 2,060 parttime students, or 62 percent of the enrollment for the 1951 spring session; there were 1,269 fulltime students or 38 percent. Most colleges and universities define as fulltime those students taking twelve or more semester hours of work. Students taking less than this minimum are considered on a parttime basis.

Fulltime enrollments, compared with those of a year ago, show a decrease in twenty-two colleges or universities. The high cost of living, cuts in scholarship budgets, fewer students on scholarships, and fewer students studying under the G.I. Bill of Rights were among the reasons given for the decrease. Five institutions mentioned military service as contributing to the drop in enrollments. A variety of other reasons, such as fewer nurses available because of staff shortages in public health nursing services, was also given.

Larger enrollments were reported by eight colleges and universities, which attributed this mainly to veterans who desired to use their G.I. educational benefits before the expiration date of such rights. Five other universities or colleges reported enrollments the same as last year, and several institutions said rises were not significant.

Parttime enrollments decreased from a year ago in eighteen universities and colleges. The reasons seemed much the same as those given for decreases in fulltime enrollments. Twelve universities and colleges showed an increase in parttime enrollments. Some of the reasons for this were expansion of facilities for evening classes, and planning courses for employed nurses at times when they are free to attend. Four institutions reported no change in parttime enrollments.

COLLEGIATE BASIC PROGRAMS

Six colleges and universities* offer undergraduate student programs leading to a degree. Four of these schools report an increase over last year in the number of students enrolled in the spring of 1951. Reasons given for the increase are (1) increased recruitment activities by colleges through work with counselors and others (2) increased interest in nursing as a profession for college women (3) more scholarship aid available (4) change in admission requirements to admit students directly to a four-year program leading to a B.S. degree and (5) progressive growth of school in keeping with available instructional facilities.

* Approved for public health nursing by NNAS.

. . . M. E. B.
. . . M. O. D.

Admission and Discharge Conferences

EDNA LAKE, R.N. and
CHARLES L. IANNE, M.D.

A ONE STORY building, sprawling and rustic, surrounded on all sides by immense windows and long porches, was once the tuberculosis unit of the Santa Clara County Hospital. It was called the Pavilion and it served only as a place to isolate the tuberculous. Treatment consisted only of fresh air and rest, and the patients received plenty of that. Some had been on the ward for six years—some for twelve. It was truly a case of "chasing the cure" and lucky indeed were those who caught up with it.

In 1927 the tuberculosis unit was enlarged to one hundred beds and the California Subsidy Law required that a service of this size employ a fulltime physician with training in tuberculosis. With a well prepared medical director at the helm many changes were made at the Pavilion. Definite rest hours were established and all activities regulated. In a few months pneumothorax therapy and surgical collapse were made available. Patients took a new lease on life.

At that time the Santa Clara Tuberculosis Association was responsible for community public health nursing, including school nursing, and for the administration of the chest clinic. The general medical clinics were carried on under the auspices of the Good Cheer Club. Both these groups transferred their work to the Santa Clara County Hospital in 1931. The Tuberculosis Association's field nurses were transferred to the county health department.

However it was noted that in spite of the better coordination of nursing service the enlarged group very often lacked the fundamental knowledge of tuberculosis therapy. The nurses were unable to tell patients just what they might expect in a sanatorium or what to do in home care. It seemed true that the patients often knew more than the nurses about tuberculosis. A program of in-service education was begun and carried out over a period of time. Public health nurses, social workers, and representatives from interested community organizations attended monthly conferences, at which time family case studies were reviewed. Lectures on various aspects of tuberculosis and therapy were also given.

Due to newer casefinding methods an increasing waiting list of about fifty patients existed in 1935. No funds were available for new beds. To meet this situation the sanatorium was converted into a hospital workshop. Collapse treatment was initiated and a short hospital stay arranged for asymptomatic cases. Patients with active tuberculosis and positive sputum remained until asymptomatic, and sputum conversion had occurred. With the cooperation of the county welfare department patients requiring only bedrest were returned to their homes, thus eliminating the boarding home feature from the sanatorium. From the public health point of view this removed the infectious cases from the community and sent others home as quiescent, noninfectious cases to continue their rest program until ready to return to work or school. The waiting list soon vanished.

THE SPEED IN admission and discharge called for streamlining the procedure for

Mrs. Lake is chief nurse, Sanatorium Clinic, and Dr. Ianne until recently was director of the Sanatorium at the Santa Clara County Hospital at San Jose, California.

securing the public health nurses' field reports on the home situation and specific needs of the patient. A form was prepared for noting detailed information of economic, social, and physical data of the household. The medical director used this information in deciding about home care when the time arrived for discharge. Occasionally, in order to admit an emergency case, a clinically well patient was discharged to complete his rest program at home without adequate preparation of the home. Hardships resulted to the patients and the others at home.

With the war's end in 1946, a waiting list had been built up again. Many patients with quiescent or arrested lesions who had worked in war industries needed readmission. The county's population had increased by 100,000 in the war years. Yet no increase in beds had been considered.

Plans were made to hold regular monthly discharge conferences to try to anticipate which patients would shortly be ready for discharge and to start preparation in the home for the care of the patient. After this plan had been in operation for several months it became evident that in many instances it would take months to change the home situation. Because of this a switch was made from discharge to admission conferences.

Once a month the histories of all patients admitted since the previous conference are studied. Workers in the county health department, county welfare department, the sanatorium, clinic staff, and hospital social service who know the patients are urged to be present at the conference. From the very first everyone agreed that each group had much to gain from the conference. The clinic nurse presides at the meeting. As each case is brought up the physical conditions are explained by the medical director. The public health nurse gives her report on the home environment, including type of housing, number of occupants, their age, occupation, intelligence, and cooperation. The welfare worker reports on the financial situation and the amount of aid being given to the family. At the conclusion of these reports the medical director presents a summary of the case, its prognosis, time of hospitalization, and makes his recommendations directly to each department.

Added together the reports mean many things. In some cases it means boarding minor children or more aid from the welfare department so that the mother may stay at home to give better care. In others, it means educating the family in better hygiene and nutrition. At times it means converting a porch into an extra room to make a place for the newly discharged patient. But in every instance it gives the workers more time to carry out their program of family improvement and often prevents a future breakdown for the patient.

After the conference the public health nurse visits her patient in the sanatorium and discusses his problem with him. This helps him realize that not only is he getting needed care but also that his family is looked after.

Because they have such a complete knowledge of their patients the workers are better equipped to handle their problems. The doctors and the sanatorium nursing staff benefit from these conferences too, because they are more fully aware of the patient's background as it influences his behavior. At times these problems influence the doctors in deciding the most helpful type of therapy. A young father from a family of transient field workers might have a thoracoplasty or lobectomy done instead of a pneumothorax or pneumoperitoneum, since he could not be depended upon to return regularly for refills.

These admission conferences have proved so effective that the discharge conferences are almost unnecessary. The conferences have shown where the good homes are and which patients can be discharged a little sooner than planned when a bed is needed in an emergency. It means better care for the patient during his stay in the sanatorium and better follow-up care when he goes home.

Listening Is Part of the Job

EDITH H. HILDEBRAND, R.N.

AT THE INTERNATIONAL Convention for the Safety of Life at Sea, held in London in 1929, it was agreed that all ships at sea and all land stations handling radio traffic be required by law to listen for distress signals at fifteen-minute intervals throughout the day, and when calls for help are being handled in their vicinity radio operators be required to stand by, listen, and give aid as needed.

All of us could doubtless work more effectively with people—those we serve, those we work for, and those we supervise—if some such code could be adopted by our profession or if we as individuals could learn to be more discriminating listeners. The purpose of this article is not to urge new burdens for your already heavy schedule. It is an attempt to look at the role of the public health nurse from a somewhat different angle and perhaps give the nurse herself a new slant on her job.

The public health nurse has many responsibilities which we accept as basic for her service in a community health program.* What then do we mean when we say she should also be a good listener?

Here we are talking about a person skilled in the understanding of interpersonal relationships and in the art of creating an atmosphere in which people can work through their own difficulties. She helps produce situations and emotional climates in which feelings and attitudes are more susceptible to change and in which people can more easily find solutions to their problems.

This is the role assumed by the social worker who helps two harassed parents find a practical solution for pressing environmental problems. In a way it is the role of the teacher who helps a youngster to understand why he has been having trouble with grades and helps him to work out better study habits. Thus, when the nurse merely listens she may be giving a great deal, and in addition she will discover what instruction, supervision, advice, or direct services are most needed in an individual situation.

For example, mothers often ask what to do about troubling behavior in their children—problems that may be common enough but are a source of worry to parents and for which the nurse can give no formula. The nurse knows that she cannot help the mother by teaching a preventive technic in the same way she teaches the importance of immunization against diphtheria. However, although she cannot give any pat answer to the mother's questions she can be helpful if she is able to establish a comfortable relationship with her. When the mother says, "My four-year-old slept dry until six weeks ago and now he wets his bed every night," the nurse does not hasten to enumerate all the possible ways in which the child might be helped. Rather, she encourages the mother to discuss the onset of the bedwetting and helps her explore the causes of this behavior. As the mother talks it may be established that the birth of a new baby brother is associated with the enuresis. The nurse may see this connection and in the course of conversation help the mother focus

* National Organization for Public Health Nursing. Public health nursing responsibilities in a community health program. PUBLIC HEALTH NURSING, February 1949, v. 41, p. 67-79. Reprints available from NOPHN, 2 Park Avenue, New York 16, N. Y.

Mrs. Hildebrand is mental health nurse consultant, Region II, Public Health Service, FSA.

on this relationship and find ways of helping the youngster adjust to the redistribution of affection in the family.

OFTEN IN CARRYING OUT medical directions or bedside nursing procedures it is the nurse's job to give direct service. She has a very different responsibility when she is helping a person with an emotional problem. Let us look at another example. The nurse realizes that many feeding difficulties in young children are not caused by the mother's lack of nutritional knowledge but rather by a disturbed parent-child relationship. Clearly, the nurse cannot remedy this situation by taking over management of the child's meals if she is in the home only for a brief visit once a week, nor would change at mealtimes alone do the trick. To help make mealtimes relaxed and happy, instead of the occasion for a tense struggle between mother and child, she has to work through the mother. Seeing herself in the role of listener, with no responsibility to "do something," she can successfully and easily play her understanding, suggestive role. She accepts the fact that attitudes and feelings do not change by magic formula. She also knows that if she criticizes, directly or by implication, the mother will feel either guilty and defensive or resentful because her efforts to help the child are unappreciated. But if the mother gets the reassurance and support she needs to work out a better relationship with the child the results may be apparent not only at mealtimes but throughout other daily living experiences.

Perhaps the point of view of the good listener will be understood best if we quote some of the questions public health nurses ask, and try to analyze what they imply:

1. "How do you prevent the child of a nervous immature mother from growing up to be the same kind of person?" This may be translated as "How do you help a nervous immature person feel adequate in the tasks of motherhood and able to give her children the security they need?"

2. "How do you make things easier for a rejected child?" This becomes "How do you help parents accept and learn to enjoy their children?"

3. "What can you do about children who neglect a senile parent?" This becomes "How do you help children and children-in-law understand aged parents and their changing needs?"

4. "How do you get a tuberculous patient to accept referral to a sanatorium?" This becomes "How do you help a tuberculous patient make plans for accepting medical direction?"

In brief, assuming the listener role is largely a matter of taking a special point of view about your job. This is not to imply that listening is the total job but rather that it is the preliminary step to take in establishing rapport.

In addition to this point of view what other equipment does the public health nurse need for this role? The first need is for knowledge. She must know something about the differences in the constitutional equipment with which people come into life and about the diverse ways environment shapes their personalities. She must have information about normal growth and development—the behavior of two-year-olds, six-year-olds, ten- and fifteen-year-olds, young adults, and older people. She must also know her community resources, not only those of the health department and hospitals, but also those of all the welfare, religious, law enforcement, recreational, social, and other agencies through which various professional groups work with and for people in trouble.

Second, the nurse learns to appreciate what stress and emotional crises can do to people and how people react to these forces. She also learns to understand how she herself reacts to these forces. She cannot hold herself aloof from the people she works with, but must inevitably have her own feelings about them. Just as inevitably these feelings will color her thinking and actions. The nurse must also examine her attitudes toward mental illness. In her basic nursing education she has learned pretty well to accept such irreversible chronic diseases as diabetes, terminal cancer, and arthritis. She must go a step further to accept, for example, the psychopathic personality, the symptoms of which are often a violation of her deepest moral and ethical codes. Nevertheless, she must accept the psychopath for what he is—a person who is chronically ill and whose prognosis, at this stage of psy-

chiatric knowledge, is just as guarded as that of other chronic disease victims.

THIRDLY, THE NURSE realizes that the role of listener is not the carrying out of a routine nursing technic that can be learned in the classroom; rather, it is the use of her personality as a professional tool. The patient unconsciously will endow the nurse with certain attributes of former persons in his life. The nurse may be aware that the patient treats her as a mother, sister, et cetera, but she maintains her professional role of participant-observer and does not become emotionally involved in the relationship. She is not there to become sentimental but to assist the patient in working through his problems. It will often bring her great satisfaction. But here she must watch her step. As a professional person she must discipline herself and not use her personality merely to gain satisfaction for herself, to control others, or to make them dependent and accepting of her suggestions. In helping people feel more at ease and in loosening emotional tensions she must never lose sight of her main objective: to help people look more objectively at themselves and at the realities of the situation in which they find themselves. To do this successfully she must maintain an objective, professional relationship with the families she serves.

Nurses often tell the mental health nursing consultant that they are too busy to continue a relationship with an individual patient long enough to see changes in behavior and actually evaluate the results of their efforts to improve mental attitudes. This is often true. The nurse can seldom visit each mother as often as she would wish. But here is the important point: If the nurse has established a good relationship and given the mother reassuring support during a difficult period the family's door remains open and probably the mother will turn to her again for help through the next crisis.

If supervisors and staff nurses understand this aspect of the nurse's role, when the supervisor asks, "What are your plans for this family?" the staff nurse will not feel guilty if she has no routine procedure to report. She will be able to say, "I just listened while the maternity patient poured out a long story of her feelings about her mother-in-law, her husband, and the unplanned pregnancy. That was what was needed most. On the next visit I may discuss medical care, if possible, or I may need to listen again." The supervisor will encourage and stimulate such planning. That hour might have been a crucial one in the life of that expectant mother. The fact that she trusted the nurse enough to expose her innermost secrets perhaps set the stage for acceptance of the pregnancy, a decision to seek early and continuous medical supervision, and planning for the coming baby. The patient had tested the nurse, and the nurse did not react with a judging attitude. The nurse had accepted the fact that the patient was emotionally upset, and simply allowing her to air grievances was the best service the nurse could perform at that visit. If the nurse had cut short the patient's tale of woe in order to teach her the anatomy and physiology of pregnancy the patient would not have remembered a word that was said. None of us can learn when we are worried and upset.

The nurse must also understand and accept the limitations of the listener's role. Those who work in the mental health field notice in institutes and discussion groups that professional personnel are greatly concerned with extremely pathological situations. All of us, as public health nurses, are aware of the number of mentally ill persons we meet in the average community. It is extremely frustrating to know that we do not have enough psychiatric services to help these anxious, fearful, disturbed people, whose illness often affects the whole family and especially the young children. We must not only face the fact that psychiatric help is limited, especially for outpatient care, and that waiting lists are long, but also that many patients cannot accept such care, even when available, in spite of the most understanding efforts of the nurse.

WE MUST ALSO realize more and more, as our knowledge of psychosomatic medicine increases, that the patient with essential hypertension, ulcerative colitis, or cardiac asthma may be quite sick mentally. As

nurses serving these patients we must realize that we cannot always change the hostile, resistive behavior we often find in these patients. Rather, we must accept it, try not to react with hostility ourselves, and be confident that we are giving the best kind of nursing care if we can make this unhappy, unloving person feel comfortable.

On the positive side, however, we can with great justification point to the important preventive work of the nurse. As Dr. Paul V. Lemkau has said, public health nurses are the only group among the helping professions who work with large numbers of normal people in their family settings. The accurate observations we make of human behavior in relation to the newborn, the first illness, the birth of a sibling, the death of a parent, and many other crucial life situations can serve us well. The human being of any age is remarkably tough and adaptable. People tend to keep on an even keel. Faced with extremely difficult situations, they usually will come through all right if given a fighting chance and a little help at the right time.

Mental health workers are tremendously impressed, for example, by the "self-repairing" mechanism that enables a youngster to keep on growing up in spite of the inevitable crises that from time to time make him temporarily revert to more infantile patterns of behavior. One nurse told me of a six-year-old who reacted badly to a tonsillectomy. He seemed terrified after his return from the hospital, clung to his mother's skirts, cried easily, and had night terrors for several weeks. His behavior baffled the family. However, after talking it over with the nurse and seeing the behavior in relation to the frightening hospital experience, the mother was able to accept the babyish behavior, gave the child more attention, comforted him at night, and shortly afterwards was able to report that he was himself again.

Another nurse was called in to give an enema to a twelve-year-old. The boy was retaining feces. He had been given a weekly enema by his mother ever since the birth of a sister five years previously. No professional help had been sought until he finally refused to allow his mother to give the enema. The nurse established a good relationship with him, encouraged him to think about getting ready for junior high school, and in a few weeks had him give himself enemas. Soon the boy had reestablished normal bowel function and was as "grown-up" as any normal twelve-year-old. We might raise many questions about the underlying unconscious factors in this boy's relations with his parents and sister, but the dramatic success achieved through the efforts of a nurse who treated him as a responsible and self-directing individual points up the impulse toward maturity that operates when blocks are removed.

Nurses have found great value in informal group discussions of emotional problems encountered in everyday duties. In one discussion at which I was present the nurses told about different ways of motivating diabetics to give themselves their own insulin. Situations described gave leads that many of the group decided to try with their own patients. At another session a nurse was able to admit that she felt insecure when she walked into a third grade classroom. Well eight-year-olds were different from the passive, dependent children she had worked with on pediatric wards before she became a school nurse. In the discussion other nurses helped her see the teacher as a source of aid—as a person who knew well eight-year-olds as the nurse knew sick eight-year-olds. Thus the school nurse began to see how she could seek the knowledge needed for nursing in a school setting. In such informal sessions nurses can not only learn to understand their patients better but also to understand their own reactions and motivations in problem situations.

In conclusion, I would like to emphasize that the listening role is not a new or additional nursing function. Rather, it is a way of using relations between people constructively as an aid in carrying out the whole range of nursing tasks. As we accept the function of just listening at times to the parents and patients in our communities, we also accept the challenge of enriching our knowledge of human personality and augmenting our skills so that we shall be more secure in this helping relationship. Listening is part of the job!

Public Health Nursing in Subtropical Florida

LILLY HARMAN, R.N.

PUBLIC HEALTH NURSING in a resort community offers many assets as well as problems. Dade County, Florida, in the most southern end of the United States, offers a delightful year-round climate. With our public health program set up on a countywide basis each nurse has quite a large area to cover, but her travel is made easy by excellent roads and she does not have snow and ice to complicate situations.

The nurses find their work has several unusual aspects. The population is constantly shifting. Many people come down only for the winter months, returning north later in the year. A large number of elderly people needing special care have settled here permanently. And each year we must face the possibility of hurricanes.

The director of public health nursing for the County Health Department is also executive director of the Visiting Nurse Association of Dade County. The county health commissioner is a member of the VNA board of directors. The public health nursing service of the county health unit offers a generalized program including services in the public and parochial schools of the county. The staff consists of fifty-five nurses: a director, an educational director and also five supervisors, one certified nurse midwife, five clinic nurses, and forty-two generalized staff nurses. There are five clerical workers.

The VNA is a community chest organization established in 1945. Its staff consists of a supervisor and eight staff nurses. The close relationships of the two services offer many of the advantages of a consolidated nursing service, such as a joint education program for both staffs and avoidance of overlapping services. The nurses have the privilege of work experience in both services if they wish. For instance, four of the present health department staff have had a year or more experience with the VNA.

The board of the VNA acts in a dual capacity and is called on to assist with the health department program. When the department plans its countywide x-ray tuberculosis survey the members ofthe VNA board are asked to help publicize this activity. As a result this board is very well informed about the general health situation in the county and was among the first community groups to stimulate the formation of the very active Dade County Health Council.

The mobility of the people creates several health problems. The constant movement of children in and out of school presents special problems for both school and public health personnel. In 1948-1949 we had a school enrollment of 65,000 students. Our tourist children are admitted for periods ranging from one week to months to an entire year. It is not unusual for a child to be enrolled in a New

York school for two months, a Miami school for five months, and back to New York for another two months, all in one school year. The result is a constantly fluctuating school population with a midwinter peak of about 70,000.

Permanent residents also contribute to this state of flux. A large proportion of them, housed in rental quarters, shift several times in the course of a year seeking better quarters or better rents. Despite all these difficulties some 16,000 children are examined each year and about 4,000 parents are present at the examinations. Our correction of defects found in examinations totaled over 50 percent in the last year tabulated.

Trailer cities

Trailer parks constitute a serious public health problem. Dade County has 115 trailer parks with 7,689 trailer spaces capable of housing about 23,000 people—a population in excess of that found in many small communities. All of these parks are under rigid supervision by our department of sanitation. Even so, these parks, in which large numbers of people share communal baths and toilet facilities, present certain problems to the public health nurse, particularly in relation to communicable disease control. These families often tax the ingenuity of the nurses in providing generalized services. Many times a nurse must spend a whole day visiting in one trailer camp. This may include working in an immunization clinic and consultation with the nursery school teacher as well as many individual calls.

They come south to retire

Many people have an impression of Miami as the world's playground, attracting only a young wealthy group of tourists to the horse races and the tropical beaches. However, there is another large group, elderly people who come seeking the sun and decide to retire here. Many more who are already ill decide that Miami's climate is just what is needed to make them well again. In both groups there are some with small incomes. Many are on pensions, and have to live in rooming houses. When they become ill they often have no family or near friends to turn to for help. This group offers tremendous problems for the public health nurse. Many of these folk are not residents and are not eligible for hospital care. At this point we turn to other community services for assistance. The Traveler's Aid is more than busy helping with plans for this group.

Our hurricanes

Every year from September through November we must prepare for the hurricane season. Early in the summer a committee of public health nurses is appointed to work with the local chapter of the American Red Cross to make plans for protecting our population at very short notice. Our local public schools are designated as shelters and a nurse is assigned as a member of a team as soon as the alert warnings go out over the radio. The public health nurses visit all their maternity patients who are near term, as well as elderly people who are living in unsafe housing, to instruct them where to go in case the storm strikes. The nurses are always responsible for the shelter where patients with communicable diseases are cared for. They man the shelters on an eight- or ten-hour shift. The ARC is responsible for getting the nurses to and from the shelters, as it would not be safe for them to drive their own cars while a storm is in progress.

The 1947 hurricane season was attended by an extremely high rainfall. As a result the two hurricanes that year produced slowly rising flood waters from the Everglades which inundated large sections of the outlying Miami metropolitan area. Large numbers of people were flooded out of their homes for many weeks. The health department set up thirty-five typhoid immunization clinics throughout the county, and within a month 20,000 of those living in the flooded area received three injections of typhoid vaccine. About the same number were given one or two injections each.

In times such as these the nurses have to give up many of their regular duties and concentrate on emergency services. These emergency needs could not be met without the

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CLASSES THAT MOTHERS LIKE

MIRIAM L. COLE, R.N.

ONE OF THE MOST active services in the Dade County Health Unit is the maternity division which administers antepartal and postpartal clinics for white and Negro patients throughout the county. There are seventeen licensed Negro midwives working in this area. These women attend about one fourth of the births to Negroes in the county, and part of my assignment as a certified nurse midwife is working with them.

In 1949 we became interested in developing mothers' classes for Negro mothers, especially those who were to be delivered at home. Several years earlier a series of classes had been held during the clinic sessions. This practice had not been found to be satisfactory, as the patients, listening for their names to be called, couldn't concentrate on the discussions. Therefore, we set out to plan for the mothers' classes to be held quite separately from clinic sessions. I had conferences with the directors of nursing of the State Board of Health and of the Dade County Health Department, with the medical director of the MCH Division, and with the nursing staff, who knew the mothers and whom we counted on to tell the women about the classes.

We realized our first series of classes would be experimental and decided to limit the attendance at first to eight mothers and to have four one-hour sessions. The material we prepared, to be presented with special emphasis on adaptation to the educational and cultural backgrounds of the students, is divided as follows:

Class One: Maternal anatomy, fetal development, and physiology.

Class Two: Hygiene of pregnancy.

Class Three: Diet in pregnancy and lactation.

Class Four: Supplies for mother and baby and care of mother and baby after delivery.

We don't go into a lot of detail about any one aspect but try to cover the basic facts. Every effort is made to keep the outline and discussions as flexible as possible and to follow whatever leads the mothers indicate as being of special interest to them. The mothers vary greatly in their degree of talkativeness: Some will go through a whole series of classes without ever speaking unless in answer to a question, while others just bubble over in their desire to participate. We've also had some very young pupils in the children who come along with "mama" because she doesn't have anyone to leave them with. I've often wondered as I looked at those small grave faces just what they thought of the conversation and the illustrations being exhibited!

We hoped that these classes would meet the mothers' needs for satisfying, factual information and that we could count on our first few groups of mothers to act as missionaries in spreading word of the classes among their friends and relatives. And to some extent that is the way it worked.

Often the suggestion that a mother join one

Miss Cole is a certified nurse midwife, Dade County Health Unit, Miami, Florida.

of the groups is made to her either during a clinic visit or when the nurse visits her at home. The nurses are familiar with the material covered in the classes. We try to assign a staff nurse or an affiliating graduate student as associate instructor for each series of classes to provide continuity of instruction for the patient throughout her pregnancy.

WE HAVE ALSO CALLED on our midwives for help. They occupy positions of great prestige in the community and often patients will heed their instructions when they might ignore the same advice coming from another source. We have tried to integrate the material taught in the mothers' classes with the instructions given to the midwives at their monthly meetings. Many of them realize that a mother who has attended the classes is better prepared, both psychologically and materially, for the entire process of labor, delivery, and the lying-in period than is the mother who has not attended classes.

In teaching the first class I found the *Birth Atlas* useful as illustrative material. The fascination and interest on the mothers' faces as we look at and discuss the pictures showing the baby's development and growth make this a really satisfying experience. Here I try to tie in scientific terminology with the more commonly used terms for parts of the body and their functions. This class is a good one in which to stress some of the principles of natural childbirth, though from my observations I've come to the conclusion that many of these mothers, with their wholehearted acceptance of each new child (regardless of finances, other children, et cetera) and their innate recognition that motherhood is part of the role of an adult woman, have been practicing "natural childbirth" without realizing it—or, at least without nurses realizing it.

In the second class we are able to go into more detail about certain aspects of hygiene (bathing, breast care, and clothing) than is possible during a mother's regular clinic visit. In the unhurried atmosphere of the class mothers often ask questions which they might hesitate to bring up at other times. We've had some spirited discussions about the fact that a mother cannot "mark" her baby.

The third class is extremely important, since one of our greatest problems with mothers whose pregnancies are otherwise normal is too great a gain in weight. Here we are faced with a situation in which economic factors and traditional patterns dictate a highly seasoned, high fat, high carbohydrate, and low protein diet. We find the mothers are interested when we explain in detail the reasons for the suggestions made, and by reviewing the mother's diet item by item for one whole day it is possible to offer concrete examples of ways in which the suggestions may be put into effect, such as the substitution of fruit juices for bottled soft drinks.

The fourth class is everyone's favorite. We all enjoy handling the baby clothes and seeing the bath demonstration (amid chuckles and bits of advice from the more experienced members) by one of the mothers expecting her first baby. We're fortunate that almost all of our mothers breast-feed their babies, so our demonstration of feeding equipment is concerned mainly with the preparation of drinking water and orange juice. In this session we talk about the importance of the baby having his own bed, and I remember the solemn and plaintive comment of one mother after a lengthy and, on my part, enthusiastic discussion of the suitability of cardboard boxes, orange crates, and dresser drawers, "But Miss Cole, can't I *buy* my baby a bed?" At the last class we award diplomas.

Throughout I have found it helpful to encourage the mothers to bring written questions to class with them, and the questions or comments of one mother often encourage participation and practical suggestions by other mothers. I've found that their interest is better sustained and the discussion is more valuable if at the end of each session I distribute printed or mimeographed material covering the following week's subject.

Each class presents some opportunity to break down old superstitions and replace them with valid facts. For example, illustrations showing the relation of the uterus to the rest of the mother's anatomy help to prove far more graphically than words that a string or

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The Regional Conferences

THE FOUR NOPHN regional conferences, planned for 1951, are now over. There is general agreement that the members who came together in Omaha, Portland, Providence, and New Orleans found the meetings stimulating and have been given food for thought. (Incidentally food of the more mundane nature was featured also, and everyone enjoyed the breakfasts and luncheons with friends, the dinners planned as part of the programs, and the little informal snack sessions.)

The local committees worked hard and certainly deserve all our thanks. Their behind-the-scenes activities resulted in smoothly run meetings. The active participation of so many of our members as speakers, leaders, and recorders helped make the programs an NOPHN family affair. Naturally, the programs took on considerable color and individuality from those participating in them but, in general, there was a fairly similar pattern running through the discussions. Several of the speakers have agreed to let us have papers and these will be published at an early date.

In each city there was a day's session devoted to administrative problems. The termination of the MLI nursing service, contracts and fee collections, nursing in medical care plans, and hospital-community relationships were discussed in some detail. Miss Haupt said it was the wish of the MLI "to leave no scars behind" when the nursing service is discontinued at the end of 1952. With this in mind the company is helping agencies and communities study their situations and plan to make up for the expected drop in income. The study carried out in Philadelphia and New York was reported and implications for other localities noted. (See PUBLIC HEALTH NURSING, May 1951, p. 285-293. *Reprints available.*)

Directors shared freely with the conference groups their experience in increasing fee collections. Certainly, when the staff as a whole participate in the planning for setting fee scales, et cetera, fee collections go up. Emilie Sargent's report of a study carried out in the VNA of Detroit will be published in the September issue of the magazine.

Everyone was interested in the topic of hospital - medical - community relationships. Each time the subject was discussed there was a fine exchange of practical experiences among the entire group. All the speakers emphasized the value of establishing referral systems for continuity of patient care. (See page 447 for Helen Hestad's paper, given at Omaha.)

WHOLE DAY SESSIONS in three cities were also allotted to the overall topic of consultants and consultation. This subject had been given a high priority in the questions and topics sent by NOPHN members in the preconference poll. In Omaha and New Orleans John C. Kidneigh, director of the School of Social Work, University of Minnesota, was the leader, and in Providence, Leonard W. Mayo, executive director, Association for the Aid of Crippled Children, New York, led the discussion. At these conferences the participants separated into small groups for part of their deliberations. Discussions were summarized and reported back to the large meeting by group recorders. Mr. Kidneigh and Mr. Mayo, respectively, then drew together the summaries, pointing out principles and highlights.

Any organization which uses consultant service should study and analyze the role, purpose, and functions of the consultants, as

well as their relationship to boards, staff, supervisors, and administrators. All persons in an agency, including board members and staff workers, have some consultant functions, but there are certain differences. In the supervisor's relationship with her staff there is a connotation of authority. In the strict sense this is not true of the relationship between staff and consultant, unless the consultant has been clearly given administrative responsibility by the organization.

Many questions arose in all the discussions but one question was paramount throughout: How best can the specialized knowledge of the consultant be used by the organization to serve the patient and his family? (The Philosophy of the Administrative Process and the Role of the Consultant by Mr. Kidneigh will appear in the September issue of this magazine.)

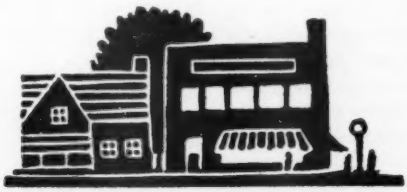
In Portland there was a panel discussion on supervision for service improvement. This was led by Ruth B. Freeman, associate professor of public health administration, School of Hygiene and Public Health, The Johns Hopkins University. Here, too, audience group discussions were carried on and recorders reported back to the larger group at the end of the day.

In each city, concurrently with the session on administrative problems, a group discussion was conducted on more effective nursing through better understanding of human behavior. The leader was Bessie Littman, who is preparing a report of the highlights of these discussions for a later date.

SCATTERED THROUGHOUT the serious hours were several lighter moments. In Omaha a skit, the Lamp of Service, was presented at the dinner get-together. The author, Nina B. Lamkin, director, Public Health Education, Nebraska Department of Health, was also the narrator. The local talent gave a splendid performance. See Mrs. Kimball's account, elsewhere in this issue, for some of the special events in Providence. There were tours of the city, tea at Gammell House, and a master of ceremonies at dinner who succeeded in getting many of the guests to solo before the microphone. One star was brightest—our own beloved honorary president, Mary S. Gardner, who in spite of a broken arm spoke inspiringly, as always.

In Portland the Division of School Hygiene of the City Bureau of Health provided automobiles for tours to scenic points of interest. A fascinating movie, This is Oregon, was shown at the dinner, and the board of directors of the Portland VNA was hostess for a tea at the Art Museum. New Orleans called out its best weather and lived up to its reputation for hospitality. The mayor sent the key to the city to Anna Fillmore, director of NOPHN. The guests at dinner were entertained by a famous Cajun monologist. He interrupted his flow of humor to tell us that public health nurses still need to sell their programs to communities. Alas, too true!

Caroline di Donato Schwartz of Seton Hall University, who prepared a report of the Providence meeting for us, wrote, "In conclusion: This type of conference is rewarding. Every minute seems to be productive. Regional meetings contribute more to the members than can be expressed. Everyone showed an interest in learning, a desire for knowledge, a realistic point of view, eagerness to consider other points of view, conscious responsibility for better understanding of human behavior, and a profound interest in our own and related professions."



The Regional Conference – Another View

MAUDE R. KIMBALL

"PARDON ME, MADAM, your expression is showing, and it's as contagious as the measles!" So said Dr. Mary Thorpe, principal of the Henry Barnard School, at the opening of the NOPHN regional conference in Providence, and while she was not referring to public health nursing enthusiasts only it struck the keynote of the entire conference and all similar ones which I, as a board member, have had the good fortune to attend. Because whether we wear name tags or not it is always possible to pick out the young, vivacious staff nurses; the sympathetic, dependable supervisors; the alert, efficient administrators, who invariably have a wonderful sense of humor; the specialized consultant, who, we decided in our day's discussion, must be a person "willing to help others grow"; and that small group of eager, curious board members simply bursting with pride to be included in such a worthwhile organization.

Yes, our expression is showing and we are proud of it. From the smallest visiting nurse agency to the officers of NOPHN we feel a deep sense of satisfaction in past accomplishment together with a new vision for future achievement, and this was constantly evident in the group of 463 (from thirteen states) attending the Providence conference. From the minute we arrived until goodbyes were said there was a continual interchange of ideas, whether at breakfast or in the large group meetings.

We certainly took to heart Dr. Thorpe's advice that we must "expect life to be problematic," and tackled one of our biggest problems, that of the withdrawal of MLI from the nursing field. Miss Haupt's explanation of the underlying reasons for this important decision was most enlightening. Perhaps this is a good opportunity to express on behalf of the small public health nursing agencies our appreciation for the valuable assistance given us by the MLI territorial supervisors during their periodic visits. Just how we will make up for this great loss is another problem for us to consider.

The always provocative topic of fees was presented by Miss Sargent in a most stimulating manner, and, as is true when two or three board members are gathered together, we all had something to add to the subject when we met for luncheon the next day. Let me hasten to explain that of course we do not want to be isolated from the professional members of the conference—we are pleased to be accepted as full partners—but, nevertheless, it is a most satisfying experience for general members to meet together to discuss the kinds of problems with which we are especially concerned. As a result of our board members luncheon we now have friends in Pennsylvania, New Jersey, Providence, and New York!

The last day of the conference came all too soon. There were still friends to see, people to meet, and unanswered questions! We spent the day discussing the "specialized consultant in public health nursing"—and I truly mean "we." Everyone had something to say, and nearly everyone was given a chance to say it. How our one lone man, the moderator, Mr. Leonard Mayo, kept us on the subject and finally summarized all the ideas under seven main headings will forever remain a mystery! There was one very heartwarming note to the entire day's program, and that was the fact that the patient's need came first.

Truly, the spirit of the conference was "as contagious as the measles." May we never be immune to this contagion!

Mrs. Kimball is a member of the executive committee of the NOPHN *Board and Committee Members Section and president of the Manhasset Health Center, Long Island, New York.*

Hospitals Without Walls

HELEN E. HESTAD, R.N.

THE HOSPITAL OF the future is architecturally perfect. The Seventy-ninth Congress has spent plenty of money to build it and it has been built in just the right spot, according to the Commission on Hospital Care. It cares for everyone—the acutely ill, the convalescent, and the patient with long-term illness. There is an outpatient department, and clinics for well children, expectant mothers, and for mental hygiene. Its well equipped laboratory is available to all. The health department has space in this building, and so has the visiting nurse association. It is truly a community hospital center. The new and strange thing about it, however, is that it has no massive walls separating it from the community, because it has moved out into the community and the community has moved in.

We have tried very hard through the years to make the walls between hospitals and public health organizations less massive by giving students a brief glimpse of the community around them while they are at school; by interchange of teaching staffs; through organization of community nursing councils; through development of referral systems; through use of coordinators. Our professional journals have done a fine job in recording the results of these efforts. The Joint Committee on Integration of Social and Health Aspects of Nursing in the Basic Curriculum outlined nine guiding principles to follow in setting up referral systems. As if the ninth principle needed emphasis, it is stated for us to remember always. It says very simply, "Primary purpose is better care of patient and family through more effective use of community agencies."* Let us consider some of the relationships which stand as walls in preventing some patients from getting the "continuity of care" they need.

First, there is that great solid wall of hospital relations. Those of us representing health and social organizations must keep informed about the economic life and aspects of the hospital of today. We must do this if we, in turn, hope to interest hospital administrators in our services. One simple and excellent way for public health nurses to get into hospitals and learn in a functional way is to plan together with the hospital staff for "tours for expectant mothers." Here patients and nurses learn about hospital routines and services, about costs of different accommodations, terms of payment, and what the "fine print" on insurance policies really means. The patients meet the hospital personnel who will care for them and they learn how as patients they can best cooperate to make their hospital stay a happy and satisfying experience. The public health nurses listen to the "language" of the hospital, just as the hospital nurses listen to ours. Furthermore, when these informed patients, now associated in the minds of the hospital staff with the public health nursing service, come in for delivery and everything goes off smoothly the hospital people understand better what we are trying to do. Physicians, many of whom haven't been sold on supplementary class instruction, begin to appreciate our services also. So this kind of public relations venture is welcomed with open arms by hospitals and physicians alike when they understand what such programs can mean to them and to their patients.

Any procedure, no matter how simple, which helps agency and hospital staff nurses build a relationship based on mutual feelings of integrity and respect for one another's job nets new referrals from the A number 1 source, the nurses themselves. After a recent

* Carn, Irene, and Mole, Eleanor W. Continuity of nursing care. PUBLIC HEALTH NURSING, June 1949, v. 41, p. 343-346.

joint meeting with the hospital nursing staff a new referral came to our organization. Since the patient's care involved an unfamiliar technic arrangements were made for the supervisor in the ward to give our staff a demonstration. She was pleased by our appreciation of her skill, and in turn, set out to learn more about our services. Today she is one of our "promoters."

THE NEXT WALL we'd like to push away this very day is one which blocks the best of referral plans. It is the false conception that the VNA cares for only the poor. This affects both hospital and VNA relationships with the patient. This erroneous impression is enhanced when referral plans are in effect only for patients who are financially disadvantaged. Most nurses are allergic to the subject of fees. In our community we are developing referral plans in voluntary hospitals. Attractive fliers, prepared by the VNA, help the hospital nurses in selecting patients who need further nursing care at home and help them also to discuss fees. It is hard even for some public health nurses to understand and explain that federated financing only helps underwrite some basic costs, and that there is a charge when families can pay. This is also a startling awakening for many people who find they didn't really understand what is meant by "everybody gives—everybody benefits," and so they have gone without a service which could have added to their comfort and speeded their recovery.

In this insurance-conscious age we would do well to see that provision for nursing care benefits is included in prepayment health insurance plans. Such measures would strengthen our relationships and prestige with all community groups.

About the last wall, medical relationships, we find little in print. In the literature about referral plans we are told that a physician should be on our "team." In the community hospital of the future physicians and nurses will work together more and more in the spirit of the team. The very physical and psychological structure of the hospital will foster such relationships. Perhaps other conferences and workshops will point out ways of working with some of the authoritarian attitudes present in hospitals and public health organizations today which result in socially undesirable characteristics and handicap team action.

The walls about us, weakening relationships among health workers, are cracking and falling. It is well to remember that hospitals are community agencies too!

Miss Hestad is director of the Dubuque Visiting Nurse Association, Dubuque, Iowa. This paper is based on her talk at the NOPHN *regional conference in Omaha.*

Classes That Mothers Like

(Continued from page 443)

ribbon tied around the waist will not keep the baby from "rising" into the mother's chest. The mothers then see for themselves that such a thing is impossible.

In looking back over the year in which we have conducted these classes I remember this: the relaxed and happy attitude of one elderly primapara who beamed when I visited her and said, "Miss Cole, I just couldn't have gone through with this without the classes." I remember the quiet sureness with which a very young mother lovingly fed, bathed, and handled her baby. I remember the comments of many of the mothers who couldn't understand why "everyone" didn't come to class and learn more about themselves and their babies.

All of these experiences bear witness to the fact that though many of our mothers are conservative and cautious about accepting new ideas, we are making slow but steady progress in the use of mothers' classes as one way of improving the quality of maternity care available to the mothers of our community.

The Plus Value In Annual Reports

BERNADINE CERVINSKI

Illustrated by
WILFRED M. BASKA

IF YOU ARE A fluent writer of reports you'll find nothing of interest here! But if you are one of the many who must prepare a summary of activities or service at the end of the year with only the enthusiasm for the job and cold facts as a basis for writing, tarry a while.

Thousands of reports are written or "just put together" for thousands of boards, commissions, presidents, governing bodies, communities, each year. How many have real reader appeal? Five? Six? Sixty? A thousand?

"But reports take time and they aren't easy for us to prepare—all those long tables and nobody reads them!"

Who's to blame? The writer? The reader? The subject matter? The editor?

When a report is written it is meant to be read and understood by some specific person or group. Remember, the reader has rights too! He expects something more than just accuracy. Even 100 percent accuracy doesn't compensate for dryness. An annual report should be fairly brief, attractive to the eye, easy to read and understand, and still present a complete picture. It is supposed to measure something—the number of clients or patients, amounts of money, types of services, et cetera.

In a bulletin* prepared for the National Publicity Council Beatrice Tolleris points out that in addition to a mere record of events an annual report can teach new and important facts about the social and health conditions which give an agency or department its reason for being. It can help to reach a new and wider audience and to gain public support for next year on the basis of this year's report. It offers an opportunity to indicate needs as the facts reveal them. And more important, it provides a chance to talk about the whole program, to appraise its accomplishments objectively, and study the reasons for its failures. With its help will come deeper community understanding of the underlying objectives of the work of the agency or group.

An annual report must have statistics to support its testimony if it is to be a true picture. Yet statistics usually scare readers away. So the writer has still another job to do. He must withstand the impulse to put in all the lists and tables just because he has them all tabulated! Rather, he will make a selection of statistics on the basis of those which are absolutely necessary as the backbone of his report.

When the problem has boiled down to those facts and figures which are necessary to tell "all" imagination and ingenuity should take over. How shall the story be told? Shall it be by narrative alone, long lists or tables, or shall the writer profit from the experience of advertisers and use graphic presentation? It is this choice which decides the extent of the "plus value."

Miss Cervinski is director of the Division of Health Education, North Dakota State Health Department, and Mr. Baska is a member of the staff.

* Tolleris, Beatrice K. *Annual Reports, How to Plan and Write Them,* National Publicity Council, 1946.

Graphic presentation it is then!

The primary purpose of the graph is to present numerical data in visual form. With the growth of its use in numerous fields of endeavor, the functions of the graph have multiplied. It is a means of presenting visually tables of statistics in a simple, readable, and interesting form. It also makes clear indiscernible facts which might be overlooked in tabulated data. It facilitates the presentation of facts for comparative purposes, and in many instances the graph indicates significant facts not obviously apparent in numerical form. Perhaps the most important things about graphs to the report writer are the time and effort saved in analyzing statistics and tables.

The graph may be used to portray the past, the present, and the probable future. It can be used for research purposes and historical comparisons, for analysis of current situations, and for forecasting the future.

Graphs may be classified as line graphs, bar charts, area diagrams, solid diagrams, statistical maps, graphs of relationship, and graphs of computation. We'll take a quick look at those which can be used most easily by both amateur and expert report writers.

As an attention getter the pictorial graph is most important. Pictures aid in attracting attention to the graph and heightening interest in the subject matter presented. Frequently they convey the description of the data more quickly and effectively than a lengthy title.

Pictures may be used in a number of ways as an aid to graphic presentation. The picture itself may present the comparison as a form of area diagram, solid diagram, or multiple unit bar chart, it may be superimposed on a bar chart, or it may be used as background for a graph.

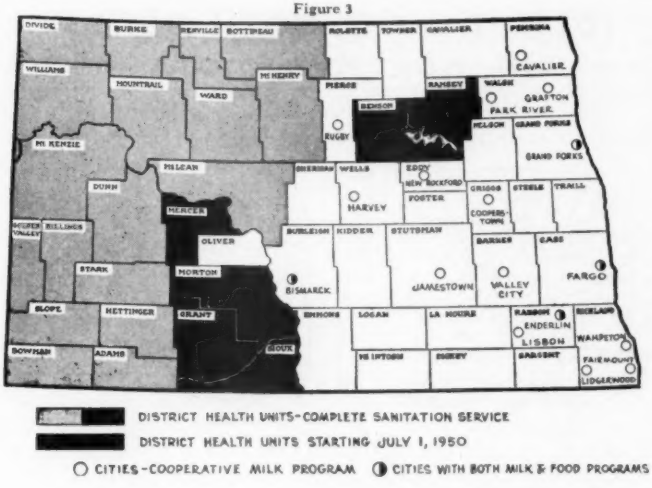
The little nurses marching across the page in figure 1 will catch the attention of the

Figure 1
PUBLIC HEALTH NURSING ACTIVITIES

reader much more rapidly than a list of services which tell the same story. This is a form of bar chart. It doesn't take the reader long to contrast the length of these lines and estimate the proportion of time which the nurse spent on each phase of her service.

Bar charts are the most effective form of presentation for a comparison of a very limited number of values, generally not more than three or four, or when comparing quantities specified for given places, types, or kinds. (Figure 2).

Figure 3

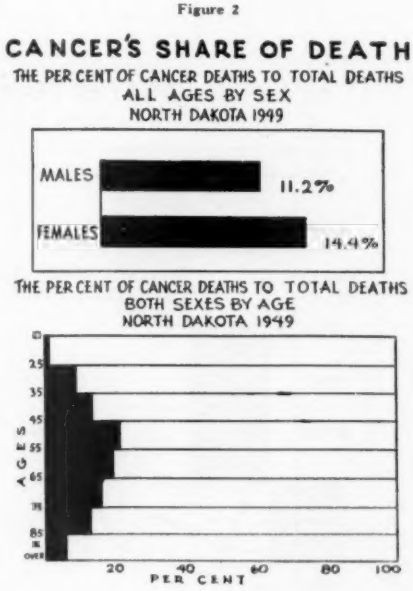


The illustrated map or map graph is an excellent means for showing the statistical distribution or location of a specific commodity. It may be used in any type of report. Figure 3 shows how one state used a single map to indicate four situations existing in its counties at a specific time. Pictorial symbols could have been superimposed on a map to illustrate similar facts or other conditions.

Pictorial presentations can be prepared by a commercial artist, an amateur, or a "scissors" artist. This places the method within every writer's means. A variety of symbols may be purchased from commercial chart makers and from some art stores. Sometimes it is possible to enlist the aid of students in art schools to do illustrations.

Another important "plus" to be considered is the pie diagram or pie chart (Figure 4). This is used to contrast the component parts of a single total. On a graph of this type absolute data are not depicted. Rather, actual numerical data are converted into percentage form for construction purposes. The two important tools for this project are a knowledge of arithmetic or geometry and a compass. A pie chart is eye catching, easy to understand, and does have popular appeal.

Figure 2



Line graphs are probably the most widely used type of illustration. These present vary-

Figure 4

TOTAL DEATHS, BOTH SEXES IN NORTH DAKOTA

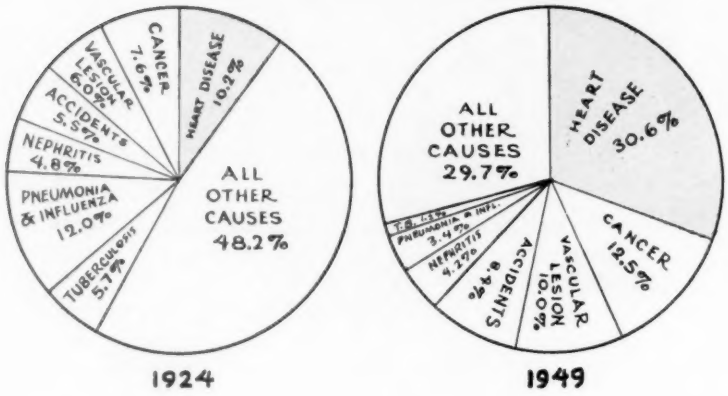
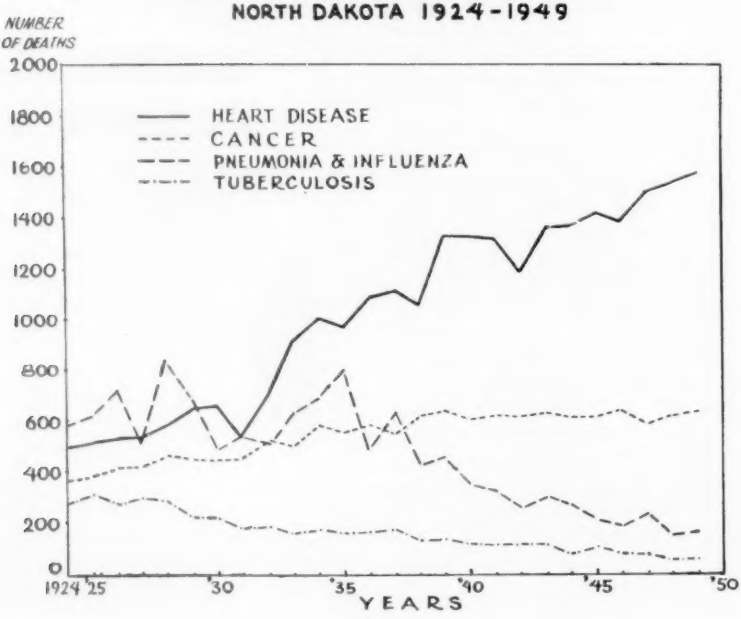


Figure 5

DEATHS FROM SELECTED CAUSES NORTH DAKOTA 1924-1949



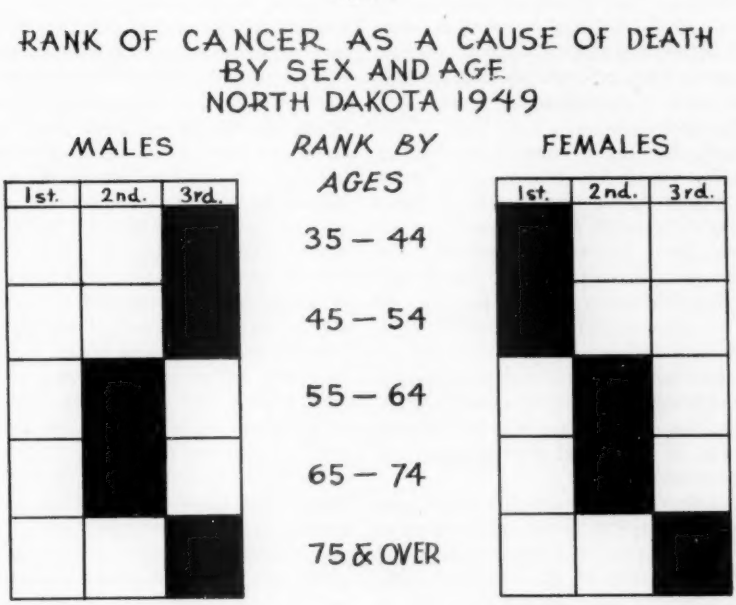
ing quantities in the form of a line or curve which moves across the face of the graph. Fluctuations in the line make it possible to obtain a quick visual picture of the "trend" of the data and the individual variations over a period of time. Figure 5 tells a number of stories about the four diseases listed and can be easily read by an individual who has no knowledge whatever of statistics.

The semi-solid area bar is another aid used successfully. The checkerboard effect catches the eye and tells the story so well that no other analysis is needed (Figure 6).

The plus value in annual reports includes much more than has been covered here. Books have been written on the subject. These few comments point out some of the ways of handling statistics which give the annual report a lift over the boundary line which separates the average from the interesting report. And the illustrations are those which may be utilized with or without outside technical aid.

At this time of year a stream of annual reports from public health nursing services of all types and sizes reaches the NOPHN office. The variety of style and of art work, the ingenuity used in making the facts intriguing, are impressive. More and more reports are being prepared with "real reader appeal." A good many are informal, down-to-earth reports, the kind the man in the street—and the woman in her kitchen—will pick up and read through. Reports are really coming into their own. If you'd like to review some of these write to NOPHN for the Loan Folder on Annual Reports.

Figure 6



Civil Defense

In the spring the editor wrote to directors of nursing services in areas which are thought likely to be target areas if an atomic attack should come. Inquiries were made about the role of the public health nurse in morale building in these tense times and her preparation for serving during an atomic emergency. The two reports which appear below are the first to come in answer to these questions. As others are received, we shall share them with our readers.

Detroit Nurses Prepare

MARION A. MILLS, R.N.

THROUGHOUT THE STATE of Michigan selected nurses—usually those in teaching positions—have been sent to workshops on medical and nursing aspects of atomic warfare. These nurses have returned to their agencies with the task of sharing the pertinent facts with all nurses.

In April 1951 the Visiting Nurse Association of Detroit started classes for its staff, including professional and practical nurses and physical therapists. Eight hours of instruction were given, in two-hour periods. The following were covered: atomic energy and the bomb phenomenon, medical and nursing aspects of explosion injuries, and civil defense.

Throughout the classes emphasis was placed on the need for knowledge and preparedness of each individual within the community, if the threat of atomic warfare is to be met with a minimum of panic and disorganization of existing facilities.

The reactions of the group as a whole were very interesting and certainly prove the value of correct information as a factor in reducing fear. The majority of the staff had little specific knowledge about the actual damage to be expected from atomic bombing and therefore were unable to distinguish between grossly exaggerated rumors and facts. The facts are serious enough but not so bad as many of the rumors we hear. As the classes progressed the nurses gained more comprehension, particularly of the dreaded radiation hazards and the ways and means of personal protection. The unknown was replaced by a sobering realization of the job to be done, or more important, perhaps, the knowledge that there is much that can be and is being done to prepare us for this type of disaster. The last two hours of instruction were devoted to civil defense with particular emphasis, of course, upon the preparations being made in the Detroit area, the plans set up by the Medical Section of Civil Defense for care of the large number of casualties expected, and the role nurses would be expected to assume.

We think that the nursing staff now has a sound basic knowledge of the principles involved in atomic warfare. This knowledge should help them meet the great demand which may be placed upon them and should enable them to interpret general community plans to the public.

How much of this information should be given to patients and their families? Is it

Miss Mills is industrial nursing supervisor, Visiting Nurse Association of Detroit.

advisable to stimulate thinking about individual family preparedness and to recommend actual preparation? These questions were discussed by our supervisory group. Since we have had no such formal request from civil defense headquarters it was thought that for the present it would be better not to initiate conversation along these lines unless the individual family situation seemed to warrant it. Many families in the district have already asked advice regarding food storage and the safety of packaged foods and water for drinking. The nurses are encouraged to answer all questions whenever possible and to combat all rumors. The official defense leaflet *Survival Under Atomic Attack* was given to each staff member and she is encouraged to carry it with her for reference. This official booklet in many instances will help to verify her information.

In addition to the teaching of medical and nursing aspects of atomic warfare there is the responsibility of preparing nurses for unusual conditions which might arise in the event of atomic warfare. Several members of the Southeastern Michigan League of Nursing Education have been appointed a subcommittee of the larger Committee of Nursing for National Security in Greater Detroit. This subcommittee has been given the responsibility of reviewing with the Medical Section of Civil Defense and the local medical society the question of standing orders, home deliveries when there may or may not be a doctor available, intravenous injections for medication, feeding, or blood transfusion, and the suturing of minor injuries. It is hoped that by the middle of June all nurses in the area will have had their basic preparation for nursing in atomic disaster and that these specialized subjects can then be taught under the auspices of the Southeastern Michigan League of Nursing Education.

Although eight hours instruction for each nurse represents considerable agency time it was thought that this expenditure was warranted by the gravity of the situation. The possibility of atomic warfare is with us today even if the present world situation is to be peacefully settled. The more constructive possibilities of radioactive isotopes being used in medicine, industry, and agriculture are constantly increasing and we should all be familiar with progress in these fields. While pressure for education about the destructive use of atoms and radioactive isotopes and their effects upon man is great and the need immediate, the information gained can help us to understand better the expanding constructive uses which are resulting from atomic fission.

Philadelphia Plans for Civil Defense

DOROTHEA McKEE, R.N.

EACH MEMBER OF the staff of the VNS of Philadelphia has had a two-hour unit on nursing in atomic warfare which was given by one of our assistant supervisors who attended the three-day institute in Lancaster sponsored by the Pennsylvania SNA. The unit was a summary of the material presented at the institute.

Our two-hour lecture consisted of a very simplified description of an atom bomb, the injury zones, and a more detailed discussion of the types of injuries which may be expected. Emphasis was placed on the methods for self protection which the nurses can share with the families they visit. There was some discussion of the management of injuries and the nurses' responsibilities for first aid measures, as well as a brief outline of Philadelphia's civil defense plans. It is our intention to follow these two-hour units with two lectures

by physicians, one unit on the emotional aspects, the other on treatment of injuries. These lectures have not yet been scheduled but we hope to plan them for the near future. Arrangements are being made for one of our staff nurses who has completed the Red Cross first aid instructor's course to conduct first aid classes for other staff members who volunteer to attend the sessions.

To date our nurses have initiated no discussion of an atomic disaster, but have tried to allay fears by answering questions raised by families with practical advice regarding protection and survival technics. Most questions raised by families center around the preparatory measures. Richard Gerstell's, *How to Survive an Atomic Bomb* is available for reference in each of our branch offices.

As far as I have been able to learn no definite steps have been taken to prepare nurses to meet "unusual" conditions, such as home deliveries without a doctor in attendance. Questionnaires have been sent to the alumnae associations of each nursing school in the state to ascertain their interest in refresher courses and to obtain suggestions for the content of these courses. The question most frequently raised in the four institutes which have been held in Pennsylvania was how and where to gain experience in intravenous procedure, but no definite suggestions were secured for the content of a refresher course.

Since the four state institutes have prepared nurses to conduct classes on nursing in an atomic disaster, efforts will be accelerated to prepare other nurses to participate effectively if the need arises, and more planned programs will be developed to teach survival technics to lay groups.

It seems to me that the emphasis of these institutes (at least, the one which I attended in Philadelphia) on the positive practical technics for protection, for the care of the injured, and the opportunity provided to discuss together our responsibilities and how to meet them, has helped build morale for the nurses. This increased confidence in their ability to help will be shared with the individuals and families they serve in their daily jobs and cannot fail to have a real morale-building effect.

Miss McKee is assistant educational director, Visiting Nurse Society of Philadelphia.

In Subtropical Florida

(Continued from page 441)

excellent cooperation of volunteer workers, the American Red Cross, and many other groups in the community.

Assets of the Southland

The subtropical climate makes for extremely pleasant working conditions. The average year-round temperature is 74.6 degrees; in August, 82 degrees; in January, 68 degrees. Our nurses wear seersucker uniforms and white oxfords the year round. Very few working days are lost because of the common cold. The average sick time is four days per nurse as compared with eight or ten in eastern and northern states.

In many aspects public health nursing in a resort area presents entirely different problems from a program in static population communities. New problems are created by the nature and location of the population. On the other hand, many problems are completely eliminated by the balmy breezes of a subtropical climate.

Miss Harman is director of public health nursing, Dade County Health Department, and executive director, Visiting Nurse Association of Dade County, Miami, Florida.

International Health

CHILD GUIDANCE IN GERMANY

The Medical Affairs and Welfare Branch of the U. S. Office of the High Commissioner for Germany (HICOG) had a tremendous task in filling such basic needs as shelter and food when the situation in Germany was desperate. It is now moving into areas of much deeper human needs, helping with emotional difficulties.

The branch has helped establish several child guidance clinics in Germany on the American principle of teamwork among the psychiatrist, psychologist, and social worker. The idea of such a team is revolutionary in Germany and is also serving to reeducate professional people. Often they feel that one person can handle the job alone, so why use the others? Or if three people must be on the staff, then surely one must be more important than the others! Cooperation among equals is not easy to learn, yet with help from the Americans and growing enthusiasm among the younger workers it can be obtained.

There is a new approach to dealing with people: no more giving of advice, no more quick judgments, no more manipulation of the outside situation. All of these methods were once dear and familiar to German doctors and social workers and indeed close to the whole authoritarian pattern. Instead there is patient listening (even to children) no accusations, no quick remedy, but real understanding and acceptance. The child and his parents are helped to find their own way. Thinking in terms of self-determination has not yet penetrated and is only beginning to be felt in child guidance clinics.

Social workers in Germany are not yet so well trained as their colleagues in the United States, but they are lively interested people who have chosen their profession because they like people. They gain courage in their own work by hearing about a country which bases its social work on respect for each human being. There is also the beginning of thinking in terms of prevention and cooperation by other forces in the community, such as the school and youth workers. The broader concept of social welfare and its relation to community life is becoming better known in Germany. But it is only the beginning.

Abstracted from an article in the HICOG *Information Bulletin* by Gisela Konopka, assistant professor of social work at the University of Minnesota.

INFLUENZA

Ever since the gigantic influenza epidemic of 1918 which swept over the entire world and took more lives than World War I, efforts have been made on national and international levels to prevent a recurrence of such a disaster. The World Influenza Center in London, organized by WHO in 1947, functions in two ways. It keeps a continual watch on the development of samples of influenza virus sent in by thirty regional centers and it has undertaken a longterm research project with the object of finding an effective vaccine against the different types of influenza virus. Had the 1948-1949 outbreak become as serious as the one in 1918 it would have been possible to prepare vaccine *in time* to prevent disease from spreading across the entire world.

—WHO *Newsletter*

DEATH FROM TUBERCULOSIS

The World Health Organization has reported a general decline in tuberculosis deaths since 1945. The report, which covers thirty countries from 1937 to 1949, shows a striking drop in postwar deaths in the European countries who were at war between 1939 and 1945.

Both France and Italy have shown startling improvement since the end of the war, while New Zealand, Denmark, and the United States continue to reduce their already low tuberculosis death rates.

The story from Istanbul is sadly different. The tuberculosis death rate is 235 per 100,000, as compared with 19 per 100,000 for Denmark. The entire country—Turkey—has 400 registered nurses and needs at least 40,000. With 300,000 tuberculous cases in the country, there is bed space for 3,500. In 1950 the Turkish government called on WHO to assist in establishing a training and demonstration center. Ten months later the center was functioning. Twenty-six doctors had undergone an intensive course in tuberculosis work and a series of lectures and demonstrations had been given to thirty young women who were preparing to work as nurses in the tuberculosis control program. The program is gradually being extended to include x-ray examinations, BCG vaccinations, and educative measures. The center is rapidly becoming a model dispensary and is expected to serve as a pattern elsewhere in Turkey as well as in other eastern countries.

—WHO *Newsletter*

MALARIA CONTROL

Yellow fever is no longer the dread scourge of Africa, for during the past ten years over twenty million people have been inoculated against the disease. Malaria, however, remains the greatest single obstacle to African development. Although the large population centers are now under local control measures little has been done for the protection of rural populations. It is still popularly believed that the African native has a high degree of immunity to the disease, but this immunity is paid for dearly and at great cost to infant life.

In the heart of the Arabian desert there are oases so highly malarious that wandering Bedouins visit them only once a year to collect the date harvest. It is believed that this was a factor contributing to the traditional homelessness of the Bedouin. He never acquired an immunity to the disease and hence could never settle on an oasis. Measures are slowly being advanced and public health authorities have requested WHO to train local doctors in modern malaria control methods.

In Afghanistan, too, the government has asked for a WHO malaria control team, and the first public health measures have been undertaken in the Oxus River valley. Although first encountering difficulties in entering homes because of the purdah system—in which no woman may appear unveiled before strangers—the team was welcomed in many homes as soon as the potency of DDT became known. The team sprayed 50,000 rooms, thus protecting a population of 45,000 in seventy-two villages scattered over an area of 175 square miles. Although the data are still being analyzed the people of these villages report that for the first time in their living memory there was no sickness among the peasants during the autumn harvest period.

—WHO *Newsletter*

Ideals are like stars. You will not succeed in touching them with your hands. But, like the seafaring man upon the desert of waters, you will choose them as guides and, following them, reach your destiny.—CARL SCHURZ

New Books
And Other Publications

FLORENCE NIGHTINGALE

Lucy Ridgely Seymer. New York, Macmillan Company, 1950. 154 p. $1.75.

This book presents in a vivid and delightful manner the story of Florence Nightingale's life of public service. Mrs. Seymer shows feeling and understanding as she leads the reader to a greater appreciation of the life and work of this outstanding woman. We read about the early childhood and youth of Florence Nightingale and her struggle with her family and a Victorian society. The author shows not only the effective way in which Miss Nightingale later dealt with pressing problems but also her remarkable ability to get things done through the medium of other people. Her work during the Crimean War is not seen as a climax but as an episode in a remarkable career.

The author illustrates well Miss Nightingale's qualities and achievements as an educator, a writer, and a reformer, as well as the initiator of modern nursing. The chapter dealing with Miss Nightingale's work for India presents a thrilling aspect of her life's work which is not generally well known. Appendix II includes Minding Baby (from *Notes on Nursing* by Florence Nightingale). This delightful chapter adds enjoyment to a book which should prove to be of interest to lay as well as professional people.

—Ann Peverley, R.N., *Assistant Professor, Public Health Nursing, McGill University, Montreal.*

PERSONNEL ADMINISTRATION IN PUBLIC HEALTH NURSING

William Brody. St. Louis 3, C. V. Mosby Company, 1951. 209 p. $3.25.

The author has clearly presented material which shows how to apply sound merit principles to the public health nursing field. These principles are applicable to any public health agency, whether official or voluntary, large or small.

The author stresses the importance of the agency's adopting a statement of personnel policy which will be well understood by all administrators who have responsibility for developing and administering an effective personnel program.

The uses of position-classification in relation to selection, placement, training, performance-evaluation, promotion, and transfer are explained. Emphasis is placed on the fact that the actual duties and responsibilities of a job determine its classification. The point is worth emphasizing. Numerous examples can be cited of nurses who have the mistaken belief that jobs are classified on the basis of the qualifications of the incumbents.

The chapter on recruitment should be especially helpful to public health nursing administrators. The relative value of various methods of recruitment is discussed. The relationship between agency prestige and success in recruiting is brought out. Agencies which have reputations for good community service and are known to have high standards tend to attract better candidates, because less desirable candidates gravitate to agencies where competition is less keen.

One chapter is devoted to the selection process, the objective of which is to provide employing agencies with the best possible candidates. The relative merits of various types of tests are considered. The type of test to be used should be determined by a careful analysis of the duties in the positions to be filled. The author appropriately discusses the probationary period as an essential part of the examining process. Too often agencies fail to utilize this period properly.

The book includes discussion of the importance of a well developed and well executed performance-evaluation process, of well planned and well administered educational programs, and of a definite and well understood compensation plan based upon position-classification.

In the chapter entitled Working Together there is a discussion of administrative procedures which contribute to successful work relationships—such as discipline, handling grievances, morale, employee organizations, employee counseling, rewards, and suggestion systems.

Typical short answer examination questions are included in an appendix. To this reviewer many of the items are "bookish."

Since most of the personnel practices discussed by Mr. Brody are applicable to a wide range of occupational fields, his study has led him into a consideration of most of the elements commonly found in a well rounded personnel program. In the opinion of this reviewer Mr. Brody has been successful in his attempt to show the precise relationship between these elements and a particular occupation—nursing.

—RUTH A. HEINTZELMAN, R.N., *Nursing Consultant, United States Civil Service Commission.*

FOOD VALUES OF PORTIONS COMMONLY USED.

Anna dePlanter Bowes and Charles F. Church. College Offset Press, 148 North 6 Street, Philadelphia, 1951, 7th edition. 94 p. $2.25.

The original purpose of the book, as stated by the author when first published in 1937, was to supply authoritative data on food values in a form for easy reference, particularly by students of medicine, dentistry, dental hygiene, public health nursing, and nutrition.

This purpose still applies, but the present edition is revised to give up-to-date information and also the number and kinds of foods listed are increased. Supplementary information in keeping with recent nutrition research includes family food plans at low and moderate cost and tables giving the sodium, potassium, cholesterol, and purine contents of common foods.

Another practical addition is the summary of the latest data on the effects on food values of various methods of cooking and food preservation.

Not only professional workers but also homemakers find that this reference book makes the comparative study of foods and analysis of diets relatively simple.

—A. JUNE BRICKER, *Chairman* PUBLIC HEALTH NURSING, *Nutrition Advisory Committee.*

UNDERSTANDING NATURAL CHILDBIRTH

Herbert Thoms and Laurence G. Roth. New York, McGraw-Hill Book Company, 1950. 112 p. $3.50.

Although Dr. Thoms and his associates have directed this book to expectant parents others concerned with family life—hospital administrators, obstetricians, nurses, psychiatrists, and pediatricians—will also find the material presented interesting and helpful.

In the preface the authors state that the title of the book explains its purpose: "To give an understanding of the natural childbirth program, particularly as it operates in the Grace-New Haven Community Hospital." Actually, the authors envision the program as training of prospective parents for parenthood. As the program functions in the clinic, doctors, nurses, and assistants work as a team. However, Dr. Thoms believes that such a program can be equally successful in the hands of the private practitioner.

The emphasis throughout the book is on pregnancy and childbearing as a normal process which should be a satisfying and rewarding experience. There is no discussion of abnormal pregnancies or births, which are considered individual problems for the doctor. The authors recognize that all expectant mothers, even with sufficient training and care, may not be able to attain the full goal they have set for themselves. They are assured that they must feel no sense of inadequacy if they "cannot do it alone."

Each chapter is short, clearly written, and is introduced by a quotation from well known obstetricians or specialists in allied fields. These quotations support the material and provide, particularly for professional personnel, reference material. Some of the misconceptions of the natural childbirth program

—namely, that it is a painless method of childbirth and that drugs and anesthetics are discouraged or withheld—are clarified. "This method does not claim to be painless but does claim to prepare for the event so that it can be experienced with a minimum of discomfort." "Medication is always available and ready." The use and effects of the various types of medications are explained to the mother, and she understands that her wishes govern the use of the medications.

The "picture story" adds much to the value of the book. Some of the pictures were originally photographed for Life magazine. There are many additional pictures which are published for the first time. The first series of pictures shows the preparation of the parents through visits to obstetrician and pediatrician, the practice of relaxation exercises, attendance at group classes where obstetricians give scientific information about conception, pregnancy, labor, and delivery, and visits to the labor and delivery rooms. The second and third series of pictures follow the mother's progress through labor and delivery and the experiences which the parents have in the hospital after the baby is born.

Whether or not one embraces the natural childbirth program in its entirety, as described by Dr. Thoms and his associates, this thoughtful explanation of the natural childbirth program will be influential in promoting better care for mothers and babies.

—HELEN L. FISK, R.N., *Chief, Division of Public Health Nursing, Maryland State Department of Health.*

THE PRACTICAL BOOK OF FOOD SHOPPING

Helen S. Hovey and Kay Reynolds. Philadelphia, J. B. Lippincott Company, 1950. 290 p. $3.45.

With food prices constantly on the rise a book such as this is timely. The book was planned and written by experts experienced in the field of marketing. There has been a great need for a book of this type, one which gives concisely and simply information which the housewife can use in order to be a careful and intelligent buyer. There is a statement on the jacket indicating that the housewife's money will be refunded if within thirty days she does not save the price of the book and at the same time find it possible to have more nutritious and tasty meals. This is an interesting approach to the book.

The first chapter points out that a good shopper must have a speaking acquaintance with nutrition, plan her meals before she goes to market, take advantage of sales, read labels, know prices before she buys, know the best way to store her food, be a good cook, and not waste her food.

The second chapter is devoted to information which should help the housewife in selecting the store and dealer best fitted to her needs. It explains how to shop at the different types of stores; why it is important to buy from a list, to know amounts to buy, to buy by weight, not by piece or cent's worth; and also why certain days of the week and times of the day are better for shopping than others. Some very sound suggestions are given which if followed should take much of the uncertainty out of food shopping. The summary describes ten ways by which an expert shopper can be recognized.

The following chapters tell briefly but adequately how to recognize quality in food, how to select food for a particular purpose or need, the various forms in which the food is sold, the number of servings per unit of measure for all the common foods, when the food is in season, and the proper way to store the food. The material is well presented and it is so arranged that it is easy to find any wanted information.

The chapter, Food for Flavor and Fun, is particularly good, for it confines information on nuts, herbs, spices, seasonings, condiments of all kinds, sauces, flavorings, relishes, pickles, beverages, and the like completely in one place. In the past it has been necessary to search for such information in many different places. As the first two sentences of the chapter say, "Little things make big differences in the flavor and fun of food. Spices, herbs, and seasonings are important to the individuality of cooking." Calling the housewife's attention to these accessories and giving her an idea how to buy and use them should help to put character into her cooking

and to make her meals more interesting to eat as well as to prepare. The last chapters answer many questions which often are asked these days regarding the "twentieth century foods that save time and work" and the new products which are constantly appearing in the stores.

This book is a guide to help the housewife become an efficient shopper and effect substantial savings in her food budget. It is a necessary adjunct to her favorite recipe book.

—EDITH M. SHAPCOTT, *Administrative Assistant, Nutrition, Visiting Nurse Association of Brooklyn.*

TUBERCULOSIS

JACK'S SECRET. A story of the effects of tuberculosis and the discovery and treatment of the disease. Project in Applied Economics, University of Florida, Gainesville, Florida. Revised edition, 1951. 32 p. 10c; discount on quantity orders.

TUBERCULOSIS. Public Health Service, FSA. Health Information Series No. 33. Order from Government Printing Office, Washington 25, D. C. 12 p. 5c. Information about the disease, written in clear simple language for the layman.

GENERAL

THE AUDIOLOGY CLINIC. A manual for planning a clinic for the rehabilitation of the acoustically handicapped. Moe Bergman. Chicago, The Audiology Foundation, 1104 South Wabash Avenue. 1950. 107 p. $1. Limited supply available.

ADOPTION LAWS IN LATIN AMERICA. Children's Bureau Publication No. 335. 1950. Order from Government Printing Office, Washington 25, D. C. 34 p. 15c.

MEDICAL TEACHING MOTION PICTURES NOW IN PRODUCTION. Bulletin 2, Medical Film Institute, Association of American Medical Colleges, 2 East 103 Street, New York 29. 1951. 27 p. Copy available upon request.

PRINCIPLES AND PRACTICE OF BACTERIOLOGY. Arthur H. Bryan and Charles G. Bryan, New York City, Barnes & Noble, Inc. Fourth edition. 1951. 410 p. $1.75.

HUMAN ANATOMY AND PHYSIOLOGY. Nellie D. Millard and Barry G. King. Philadelphia, W. B. Saunders Company. Third edition. 1951. 596 p. $4.25.

SOCIAL ASPECTS OF ILLNESS. Carol H. Cooley. Philadelphia, W. B. Saunders Company. 1951. 305 p. $3.25.

ADMINISTRATIVE HOUSEKEEPING. Alta M. La Belle and Jane P. Barton. New York City, G. P. Putnam's Sons. 1951. 420 p. $5.50.

PHYSIOLOGY OF HEART AND CIRCULATION AND ITS CLINICAL APPLICATION IN PHYSICAL MEDICINE. A symposium presented at the 27th annual conference of the American Physical Therapy Association. American Physical Therapy Association, 1790 Broadway, New York 19, 1951. 63 p. $1.

WHAT THE CLASSROOM TEACHER SHOULD KNOW AND DO ABOUT CHILDREN WITH HEART DISEASE. 1951. Single copies of this booklet may be obtained without charge from American Heart Association, 1775 Broadway, New York 19, or from local affiliated heart associations.

OCCUPATIONAL THERAPY

OCCUPATIONAL THERAPY. William Rush Dunton and Sidney Licht, editors. Springfield (Illinois) Charles C. Thomas Company, 1950. 321 p. $6.

PUBLIC HEALTH

YOUR BEST BUY. Public Health Service, FSA, pamphlet. Single copy available free. Bulk supply may be obtained from Government Printing Office, Washington 25, D. C., at 5c each; discount on quantity orders. Prepared to aid in the effort to secure public health protection for Americans with inadequate or no local health services.

SEX EDUCATION

LET'S TELL THE WHOLE TRUTH ABOUT SEX. Edward B. Lyman. New York 19, American Social Hygiene Association, 1951. 32 p. 25c a copy.

NURSING

TERMINAL CARE FOR CANCER PATIENTS. Booklet published by the Central Service for the Chronically Ill of the Institute of Medicine of Chicago. 1950. 211 p. $1.25. This survey of the facilities and services available in the Chicago-Cook County area for the terminal care of cancer patients will be of interest to many communities. Chapter VIII, which deals with the types of organized services and facilities needed in the community, is thoughtful reading for all.

PSYCHOLOGY APPLIED TO NURSING. Lawrence Augustus Averill and Florence C. Kempf. Philadelphia, W. B. Saunders Company. Fourth edition, 1951. 481 p. $3.50.

A HISTORY OF NURSING. Gladys Sellew and C. J. Nuesse. St. Louis, The C. V. Mosby Company. Second edition, 1951. 439 p. $3.75.

FROM NOPHN HEADQUARTERS

PROGRESS ON REORGANIZATION

As requested by the Joint Coordinating Committee on Structure the NOPHN Executive Committee and the National League of Nursing Education Board of Directors met on May 12, 1951, to decide which organization would become the nucleus for the new Nursing League of America. Previously the NLNE and NOPHN officers had met to discuss the question in detail and had recommended that the Articles of Incorporation and Bylaws of NLNE become the nucleus for those of the new Nursing League of America. This recommendation was adopted. (According to previous decisions the present ANA Constitution and Bylaws will become the nucleus for those of the new American Nurses' Association.) All of these decisions, of course, are subject to the approval of the memberships of all organizations involved at the Biennial meeting to be held in June 1952 in Atlantic City.

As the other national nursing organizations (American Association of Industrial Nurses and Association of Collegiate Schools of Nursing) are also closely concerned in this plan for reorganization an Agreements Committee was formed, composed of the following: Mrs. Mary Delehanty and Mrs. Gladys Dundore, representing AAIN; Elizabeth S. Bixler and Virginia Dunbar, representing ACSN; Agnes Gelinas and Mrs. R. Louise McManus, representing NLNE; and Ruth W. Hubbard and Emilie G. Sargent, representing NOPHN. This Agreements Committee will work on details for the transfer of programs, services, money and other assets, and members, to the new Nursing League of America. It will confer frequently with representatives of ANA and NACGN.

The Committee on Agreements met on June 4, 1951, and made the following recommendations to the Joint Coordinating Committee on Structure, which adopted them on June 21:

1 That the NLA Board for 1952 be composed of 24 members; that the slate be a fixed one with equal representation from each of the four organizations most involved, and that an election for a new Board for NLA be held in 1953.

2 That this Interim Board be composed of four nurses and two lay members from each of the four organizations concerned—AAIN, ACSN, NLNE and NOPHN—the four nurses to be selected from present boards of each organization and two lay members from each organization, not necessarily on the present boards; and that the following interests should, if possible, be represented on this Interim Board: higher education, hospital nursing service, public health nursing (both voluntary and official) industrial nursing, practical nurse education, denominational schools, hospital schools, with emphasis on Negro representation. It was recognized that all of these needs and interests might not be represented on the board specifically, but that they be kept in mind for advisory committees of divisions and departments.

3 That the Committee on Agreements be the committee to prepare the slate after nominations are received from the four boards.

4 That after the June meeting of the Joint Coordinating Committee on Structure, and before January 1952, the individual boards of the AAIN, ACSN, NLNE and NOPHN be asked to choose the four nurse candidates and two lay candidates from each organization for the NLA Interim Board with an alternate for each; and that names and biographical data be presented to the Committee on Agreements at the same time as the names are submitted.

It is planned to ask Mrs. Deborah Jensen of the NLNE to begin to draft the new Bylaws for NLA as early as possible during the summer of 1951, and that representatives of the

other organizations will be asked to work with her; also the Committee on Agreements will act as an advisory committee to the chief executive appointed for NLA.

At an executive session of the Committee on Agreements it was agreed unanimously that Anna Fillmore would be appointed chief executive for NLA, if structural reorganization proceeds as planned, and that Julia M. Miller would be director of the Division of Nursing Education.

JUST OFF THE PRESS

Long awaited, the revision of *Suggested Standards for Camp Nursing,* is now available. The new booklet, *The Nurse in the Camp Program,* is attractively illustrated by Gyla Brooks, supervisor, Association for the Aid of Crippled Children in New York. The material was prepared by the Committee on Camp Nursing, School Nursing Section, NOPHN, in cooperation with the National Committee on Health and Safety of the American Camping Association.

Anyone interested in any aspect of camp health will find this pamphlet of practical help. It will help a nurse decide whether she wants to be a camp nurse and it will give camp management a broad understanding of what to expect from a camp nurse. *The Nurse in the Camp Program* is a *must.* Copies may be ordered from NOPHN, 2 Park Avenue, New York 16, New York. Price fifty cents each.

* * * *

The Report of the Conference on Graduate Nurse Education is now ready and may be secured from NOPHN office at $1.15 a copy. This provocative report is the outcome of the conference held in New York, April 30-May 4, 1951. It contains the thinking and recommendations of the fifty-one participants, who came together from all sections of the United States to design in broad outline a plan for the advanced preparation of public health nurses.

PSYCHIATRIC NURSING

The Joint NLNE and NOPHN Project on Psychiatric Nursing, which was made possible by a grant from the National Institute of Mental Health, held its third conference in Cincinnati, Ohio, May 14 through May 18, 1951. The subject of discussion in this conference was advanced psychiatric and mental health nursing programs.

The purpose of the conference was to study and evaluate present psychiatric nursing practices with a view to improving psychiatric and mental health nursing education. Clara Gilchrist, associate professor, College of Nursing and Health, University of Cincinnati, was chairman. There were thirty-one fulltime participants, representing nineteen universities. Twenty-three of these participants were concerned with university educational programs for psychiatric nurses; five were concerned with university educational programs for mental health nurses; NIMH sent two representatives, the training specialist and the mental health consultant; and NLNE was represented by the curriculum specialist. The mental health consultant to the joint project participated in the planning and attended the conference for one day.

Planning for this conference was begun in August 1950. The conference members chose to work in small groups. General sessions were held on three days. A complete report of this conference will be published by NLNE.

NOPHN FIELD SCHEDULE—JULY

Marjorie L. Adams	Lynchburg, Va. Atlanta, Ga. Greenville, S. C.
Eva M. Reese	Lynchburg, Va.
Dorothy Rusby	New York City Health Department
Judith E. Wallin	Hammond, Ind. Port Huron, Mich.

June field trips not previously reported: Mary Elizabeth Bauhan, Montclair, N. J.; Judith E. Wallin, Mahoney City and Schuylkill Haven, Pa.

NEWS AND VIEWS

NATIONAL AGENCIES

The new directory of its member agencies is now available from the National Health Council. This contains concise, up-to-the-minute information about the country's major health organizations—their aims, programs, and structure. Single copies of National Health Agencies—A Directory of Member Organizations, 1951, may be purchased for 25 cents; prices reduced on quantity orders. Write to the National Health Council, 1790 Broadway, New York 19, New York.

NATIONAL TUBERCULOSIS ASSOCIATION MEETS

A record 2,500 people, leaders in this country's campaign against tuberculosis, met in May in Cincinnati for the 47th annual gathering of the National Tuberculosis Association. Dr. James E. Perkins, managing director of the NTA, cited Cincinnati as the first city in the United States to have a tax-supported municipal hospital for the care of the tuberculous. As far back as 1897 the community recognized the necessity for such a hospital.

Dr. David T. Smith of Durham, North Carolina, emphasized that tuberculosis is a preventable disease and an appalling waste, considering the fact that over 40,000 people die of it each year. Future attention, he said, should be focused on the amount of tuberculous infection in the population. As long as the germs are present there is always the possibility that the disease will develop, particularly if the economy of the country is disrupted, as happened in Europe during World Wars I and II.

Reporting on a study expected to throw light on the influence of race and age on the development of tuberculosis, Dr. Joseph D. Aronson stated that although the tuberculosis death rate is three times as high for Negroes as white people, native resistance to the disease in infancy appears to be approximately the same for both races. The study was based on the immunization of a group of Negro newborn babies and a group of white babies with BCG, and also immunization of groups of Negro and white adults. No significant difference was observed between the local reaction of the two groups of infants or the two groups of adults. Dr. Aronson and Dr. Martin J. Sokooff, who was associated with him in the study, found, however, that age was a decided factor in the reaction. The local lymphatics were involved in the reaction of infants to tubercle bacilli but were not involved in the adults, in whom the lymphatic system is less active.

Thus the type of local reaction produced by the tuberculous infection varies with age, and the variations in the physiological activity of the lymphatic system associated with age may explain why primary lesions of the lungs in adults simulate reinfection lesions in adults and differ greatly from primary lesions in children. The study indicates, therefore, that the controlling factor in the character of adult pulmonary tuberculosis is not only reinfection but also age.

Generally considered a disease of adults, tuberculosis kills 1,700 children under fifteen years of age, and the majority of these are children under two years of age. Dr. Edith Lincoln, head of the Children's Chest Service, Bellevue Hospital, New York City, asked that tuberculosis prevention begin with the child. "It might be well for those interested in tuberculosis control to stimulate pediatricians who follow children from birth through adolescence to do routine tuberculin tests as part of their regular examinations and to x-ray all positive reactors at regular intervals. This might be a means of early diagnosis of cases not found

by examining children known to have been in contact with a person with active tuberculosis."

Dr. Donald L. Paulson of Dallas told the meeting that plastic surgery is now being used to save the functions of the lung. With wire mesh and skin grafts as materials, sections of bronchial and tracheal tubes which have been surgically removed because of injury, tumor, or tuberculosis, can now be reconstructed with such success that the tissue is regenerated and the function of the respiratory system saved. The reconstruction of the tubes has been accomplished by grafting skin over frames of stainless steel wire or tantalum.

Evidence of a significant relationship between death rates from such respiratory diseases as tuberculosis, pneumonia, and lung cancer was presented by Dr. C. A. Mills of the University of Cincinnati. Although the higher death rates from pneumonia and tuberculosis in the industrial districts of many American cities, in comparison with suburbs of the same cities, have usually been attributed to inadequate housing and overcrowding Dr. Mills said that these factors are overshadowed by the deleterious effects of polluted air. Men in industrial areas have shown a more rapid increase in death rates from tuberculosis than women. Added significance is given this sex difference by the finding that respiratory tract death rates also rise strikingly in proportion to the degree of air pollution. Polluted air today is posing just as much of a serious public health problem as polluted water supplies did a half-century ago.

Research fellowships were awarded to eight scientists. Among the recipients is Helen Wago, who is undertaking a study of attitudes of graduate nurses toward tuberculosis nursing. Miss Wago is on leave of absence from her position as assistant professor of clinical nursing, Bellevue Hospital, New York. She will carry out her study at New York University under the direction of Dr. Vera S. Fry.

TUBERCULOSIS NURSING

Teachers College, Columbia University, has been given a grant of $4,000 by the National Tuberculosis Association to assist in the development of an advanced program in tuberculosis nursing. The program is planned especially for graduate nurses who wish to prepare for positions as clinical teachers, supervisors, administrators, and consultants in tuberculosis nursing. Orientation courses in tuberculosis control will be expanded to meet the needs of nurses preparing for other fields.

Sheila Dwyer has joined the Teachers College faculty to work in these programs. Nurses interested in enrolling in the advanced program should write as soon as possible to the Division of Nursing Education, Teachers College, Columbia University, New York City.

If We're Wrong, Please Write!

ARE YOUR NAME and address correct on our mailing lists? Does your magazine reach you regularly? If not, be sure to let us know. A change to a more efficient method of handling our membership and magazine lists was made at the time we moved to 2 Park Avenue. But during any change in a mechanical process involving thousands of names and addresses there are bound to be some errors. We know how irritating such errors can be and will appreciate your help in making sure that any needed corrections are made.

Our Readers Say . . .

NURSING IN AFRICA

Greetings to you from the Zambezi Valley. It is a wonderful privilege to be here in the Lord's work, a lifelong desire fulfilled. I have been with the Foreign Missionary Department of the Pilgrim Holiness Church for over four years.

I want to share some of my experiences with my alumni of Presbyterian Hospital, Pittsburgh; the Public Health Nursing Organization of Pittsburgh, and the Greene County Memorial Hospital of Waynesburg where I worked in the anesthesia department. I would enjoy hearing from all of my friends in our profession.

I live in a two-room pole and mud house with a thatched grass roof. The roof opens at the eaves but the windows are screened and that helps a lot. The temperature inside in the evening is about ninety degrees. The floor is laid with flat stones in jig-saw fashion, pressed down into mud which has dried and hardened. Rag rugs give a homelike touch. I have a nice fur rug made of animal skins in my bedroom. I cook on a two-burner oil stove, use a pressure lamp, and sleep under a net. Water is carried to my door from the Zambezi River.

It would be unusual for me to eat my breakfast and not be interrupted by someone calling me to the hospital. The hospital is another pole and mud house, small and round, with a grass roof and a hard mud floor. This house, as well as the other two houses for patients who "sit" for treatment, are only temporary. When a patient "sits" it means he has his own blanket, pots, and food. We do not furnish food, but as many as two or three relatives will remain to wait on the patient. One house has a bed made of small branches tied together with bark string and laid on four forked poles. It is particularly for maternity or bed cases. Most of the people come for treatment and return home immediately. Only those who need medication remain throughout the day. Those who do prefer sleeping on the ground. They build a fire inside to keep the mosquitoes away or to cook, or some sit or lie on the ground under a nearby tree. We do not have a laundry problem. The valley people wear no clothes except an animal skin for the woman and a loincloth for the man. Children wear nothing until they are five or six years old. I gave a small jacket made from a nightgown to a maternity patient and she took it off soon after I left her. I was successful, however, in getting her to keep the baby in a pasteboard carton which I had prepared with sheets, rubber sheeting, and pads. I also dressed the baby. The mother took great interest in this and once I found her washing the baby's clothes before my assistant could do it.

One afternoon I heard the baby screaming and hurried to the hospital to see the trouble. The mother had decided to give her baby a native bath and there she was sitting on the floor holding her baby by one arm, throwing cold water all over her, and rubbing her with the other hand. They never bother to dry the children or themselves. It is refreshing in such a hot climate and the babies learn to take it from birth. Most of the babies are fat and healthy as long as they are breast-fed, but when they begin to walk their nutritional problems begin. They are fed heavy corn meal, a few greens which grow along the river, and leaves from trees. There is nothing we can do about it, for there is no other food. The people grow corn, other grains, and sometimes pumpkin, but as for vegetables, beans, and fruits, they are almost unknown except when a mission teacher has a school and tries to raise different foods.

We have many patients with severe burns. A man was burned over his entire abdomen when he went into his burning house to get his few possessions. One of his six wives sits by him and keeps the flies away with a zebra tail. A little child and her mother are also here for burns. Both were sleeping in their garden on a ten-foot-high grass shelter. There are many such "houses" in harvest season, for someone must always keep watch for wild animals. The mother made a little hearth of mud, carried it to the shelter, built a fire, and fell asleep. The grass caught fire and the woman and child were forced to jump. The child had severe burns on one side from her waist to the sole of her feet; the woman suffered burns on her body and arm. What a time I had! I had a few bandages made from old muslin and I had to boil them every day in an iron pot outdoors. We had been in this mission station only a short time and my supplies were few. What ointment I had was soon gone, so I resorted to what I had on hand. I made a mixture of castor oil and codliver oil and soaked muslin bandages in it. After cleansing the burns I dusted iodoform powder on them, applied the oilsoaked bandages, covered this dressing with brown paper, and then bandaged them. It was remarkable how rapidly these burns healed. No medi-

cation by mouth and no penicillin. God takes care of these people!

I have also had as a patient a boy who, while fishing was grabbed by the heel by a crocodile. I have from twenty to thirty-five people coming from other villages each day with tropical ulcers, burns, yaws, malaria fever, teeth needing extraction, common cold, dysentery, diarrhea, skin diseases, and sometimes even leprosy.

But let me take you to a village for a delivery. I pack my bicycle bag, well equipped public health bag, and saddle bags with extra supplies and a light lunch. One thing I need is a flashlight to use inside the hut until my eyes get adjusted to the darkness. Invariably there are eight or ten women and a few children and babies sitting on the floor watching the woman in labor. Besides the noise there is smoke from a wood fire and old women smoking their gourd pipes. The first thing I do is to invite the visitors outside, get the patient up off the floor on to a native bed, if there is one, and then begin to set up for a delivery. Usually I have no newspaper, no chair or table, so the floor is the place. A basin of lysol solution, a small enamel basin with instruments, and a supply of cotton and clean pieces of cloth are sufficient. The patient is usually filthy dirty with old rags under her. She insists on sitting up so the baby won't come out of the rectum. If the baby is well on its way some old woman will get on the bed and stick her big toe in the mother's rectum to keep the baby from coming through. As a rule, after the people call me they let me do as I like, so I clean up the patient, place a rubber sheet under her, get her to lie down, and see her through without too much interference. It is impossible to keep out debris, because friends insist on coming in to see what I am doing and they step over the basin or drop some old rag in it, or the wind blows grass down from the ceiling. Unfortunately my small basin has no lid and if I have to boil a syringe over a wood fire I often get ashes in the water.

When we opened schools and a dispensary in this valley it was real pioneer experience. White people had never lived here before and many Africans were afraid of us. The people who suffered with yaws knew of our work, because they had walked forty-five miles through mountainous country to our main mission station. They are grateful to have a dispensary here where they can get weekly injections, for this disease is very prevalent and many children die from it. At first we lived in temporary grass shelters with cornstalk doors to keep animals out, especially the hyena. My dispensary was under a tree; the seats were of tree limbs laid across poles; my table was of cornstalks tied with bark string. Just picture me under that tree suturing a laceration or dressing those extensive burns, or dressing tropical ulcers. Along came a whirlwind of dirt and I just had to start cleaning up over again—wounds, tray, and solutions. It is such a relief to be under cover, even in small quarters. Now I have a small native bed in the dispensary for those who must lie down for treatment. My sterilizer is a standard one which I place on a primus pressure oil stove and I have a metal cupboard for supplies.

I love to go to the villages, especially on delivery cases. It is fun to improvise, to make the best of what you have, and to see how the people learn to have confidence in you. On one case the older women did not trust me to deliver the baby, but the husband of the woman ordered them out of the house and told me to keep on doctoring. I know enough of the language so that I do not need an interpreter now. Of course we are encouraging people to bring the seriously ill to the dispensary, where they will receive proper nursing care and medication. The patient suffers when he receives nursing care in the village. If there is pain in the chest someone will take a razor blade and make rows of small cuts to let the pain out. If there is pain in the head the temples are cut and goat horns pressed into the flesh to create suction and bring out the pain in the flowing blood. Sometimes they refuse my help.

For some time I have wanted to write to the nurses and I trust this gives a picture at least in part of medical work in Africa. In another year we will have a permanent building and proper equipment. We need a doctor, for the nearest one is at a government hospital about ninety miles away. He comes about once a year to visit the valley.

I wish all of you success in your profession and God's blessing in this great work of administering to the sick and wounded.

Ruth Elma Miller, R.N.
Jembo Mission
Pemba, Northern Rhodesia
Africa

See Page 429 for About People You Know

Cool answers to Heated arguments!

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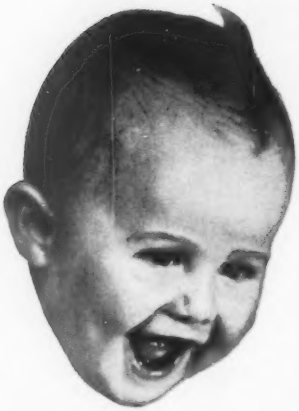
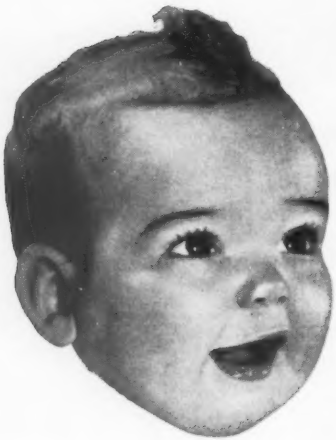
Nutritional benefits OF HAPPY MEALTIMES





WHEN a baby's early experiences with food are pleasurable, the benefits are reflected in many ways besides added pounds and inches. Zestful enjoyment of meals also helps a baby thrive emotionally!

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Advertisements in this column are accepted at the following rates: 10c a word with a minimum of $3 for 30 words or less, MONEY TO ACCOMPANY ORDER FOR INSERTION. Agency members or sustaining members may have ONE insertion up to 50 words without charge. Closing date for copy and cancelation is the 1st of the month previous to publication.

WANTED—Director of nurses, demonstration health center in large Eastern city, population 100,000; nursing staff of about 20 to 30 expected; voluntary agency, combination nursing service being planned; requirements: experience in supervision, bachelor's degree, MPH or master's degree desirable; salary dependent on qualifications; one month vacation, 5-day week, sick leave, good retirement plan. Write to Box 851, PUBLIC HEALTH NURSING magazine.

WANTED—Qualified staff nurses, well known combination agency. Program includes bedside nursing, maternal and child care, communicable disease nursing, parochial school nursing, clinic services; excellent salary schedule; beginning salary dependent upon preparation and experience; 40-hour week, liberal vacation, sick leave, retirement; accessible to universities carrying PHN programs. Write to Director, Public Health Nursing Service, 65 Chestnut Street, Montclair, New Jersey.

WANTED—Immediately, staff nurse; generalized public health nursing program established over a 10-year period; salary $250-297, depending upon qualifications and experience. Apply to Director Lawrence County Health Department, Lawrenceville, Illinois.

WANTED—Staff nurses, with new ideas, for positions in local health units in Oregon; at least $260 to start, plus expenses; liberal employee benefits. Write to A. T. Johnson, Merit System Supervisor, 1019 S.W. 10th, Portland 5, Oregon.

WANTED—Qualified supervising public health nurse for district health department in Idaho; salary $3,480 a year to start; merit system status. For additional information write J. E. Waddill, Personnel Officer, PO Box 640, Boise, Idaho.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,852-$3,536; graduate nurses as assistant PHNs, $2,540-$2,972; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

WANTED—Immediately; supervisor and staff nurses in bi-county health unit in central Illinois, generalized nursing program; supervisor: degree desired, experience required, salary $3,000 to $4,380, depending on qualifications; staff nurse: formal PH training and experience desired, salary $2,640 to $3,660; trainee: salary $2,400, annual increments until maximum. Liberal holiday schedule, 40-hour week, 2 weeks annual leave, 15 days sick leave. Write to Dr. E. M. Thompson, Director, DeWitt-Piatt County Health Unit, 113½ Magill Court, Clinton, Illinois.

WANTED—Director; generalized nursing program, city of 60,000; 8-nurse staff; requirements: bachelor's degree and supervisory experience. Apply to Public Health League Nursing Association, Inc., Room 352, City Building, Hamilton, Ohio.

WANTED—Staff nurses, generalized program in city of 25,000; salary $2,940 to $3,300, plus travel allowance; established personnel policies. Write to Dr. R. Wilson, Health Officer, Winona, Minnesota.

WANTED—Director, combination agency in NYC area; generalized service, school health program, graduate student affiliation; 16 field nurses, 2 supervisors; excellent personnel policies and working relationships; requirements: preparation and experience which meet NOPHN standards; state qualifications, date available, minimum salary. Write to John A. Darsie, President, Visiting Nurse Association of Plainfield and North Plainfield, 703 Watchung Avenue, Plainfield, New Jersey.

WANTED—Staff nurse, nonofficial agency in city of 100,000; NOPHN standards desired; car required, assistance in financing may be arranged through VNA; 3 weeks paid vacation; social security benefits; salary based on qualifications. Apply to Visiting Nurse Association, 522 Cass Street, Saginaw, Michigan.

WANTED—Supervisor, nonofficial agency, Philadelphia-Main Line area; generalized service, school health program, student affiliates; 13 field nurses, assistant supervisor; one month vacation, 39½-hour week, sick leave, retirement plan; 8c a mile allowance for use of personal car; requirements: preparation and experience which meet NOPHN standards; salary open. In replying state qualifications and date available. Apply to Executive Secretary, Community Health and Civic Association, 25 East Athens Avenue, Ardmore, Pennsylvania.

WANTED—Qualified staff nurses for generalized program; good retirement; sick leave, vacation. Vacancy with City of San Jose, salary $305-$361 a month. Vacancy with San Jose Unified School District, salary $3,100-$4,300 a year. Apply to Margaret Nelson, Chief Public Health Nurse, City Health Department, 280 S.E. Market Street, San Jose, California.

WANTED—Public health nurses and supervisor in tuberculosis, Baltimore County Health Department; population 270,000; suburban, industrialized, and rural areas; county seat 8 miles from Baltimore; generalized service including progressive school program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and special preparation in tuberculosis nursing required; beginning salary $4,000. Public health nurses: qualified, salary $3,000-$3,300; junior nurse, salary $2,600-$2,800; trainee, $2,500. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Hospital nurse consultant, public health nurses, and graduate nurses. Write to Merit System, Box 939, Santa Fe, New Mexico.

WANTED—Staff nurses; general rural program; southern Michigan; good salary. Write to Lenawee County Health Department, Adrian, Michigan.

WANTED—Staff nurse by September 1; newly created visiting nurse association 30 minutes from Philadelphia; career opportunity; beginning salary $3,060; requirements: degree with public health nursing major, own and drive car, 7c mileage allowance; 5-day, 40-hour week, social security. Write to Grace Anderson, R.N., Director, Norristown Visiting Nurse Association, 409 Cherry Street, Norristown, Pennsylvania.

WANTED—Public health nurses for generalized program in suburban area; staff education and students; 5-day week, vacation, sick leave, and retirement benefits. Write to Mr. John Davenport, Personnel Director, The Court House, Arlington County, Virginia.

WANTED—Field assistant director; 20-nurse staff, student affiliates; generalized program; retirement, social security, and good personnel policies; preparation in public health nursing, college degree, and one year in supervision desirable. Apply to Executive Director, Visiting Nurse Association, Springfield, Massachusetts.

WANTED—Educational director, child welfare consultant, supervisor for 46-nurse staff, undergraduate student affiliation; combination agency; 40-hour week; degree majoring in public health, and experience required. For full information write to Ruanna S. Gordon, Director, The Visiting Nurse Association, 401 Municipal Building, Dayton 2, Ohio.

WANTED—Qualified experienced PHN to be senior staff and parttime assistant supervisor in suburban VNA convenient to New York City; liberal employment standards; salary, $3,000; appointment before October 1. Apply to Yonkers Visiting Nursing Association, Health Center, Room 317, Yonkers 2, New York.

WANTED—Qualified staff nurse by September 1; nonofficial agency in town of 8,000; generalized program, including school nursing; 40-hour week, 2 weeks sick leave, 1 month vacation; salary dependent on qualifications; based on NOPHN policies. For further information write to Mrs. Kenneth Faile, President, The New Canaan Visiting Nurse Association, 102 South Avenue, New Canaan, Connecticut.

WANTED—Immediately. Physical therapists, experienced, preference given to nursing background; near two approved schools of physical therapy, university facilities available locally for educational plans; agency program offers service under medical prescription to patients in their homes, includes care of early subacute poliomyelitis patients, provides supervised experience opportunity for physical therapy students; 5-day week, liberal holiday, vacation, and sick leave allowance. Write to Ruth E. TeLinde, Executive Director, Visiting Nurse Association, 1038 North Cass Street, Milwaukee, Wisconsin.

WANTED—Public health nurse for small rural agency; starting salary $2,100-$2,200. Write to Miss Fanny McIlvain, Downington Visiting Nurse Association, Downingtown, Pennsylvania.

WANTED—Staff nurses for generalized public health program; salary $260; vacation, sick leave, and retirement benefits. For further information write to Health Department, Sheboygan, Wisconsin.

WANTED—Public health nurses, educational director, consultants in mental hygiene and physiotherapy for combination agency, Ohio capital city, population 400,000; generalized service, including bedside care; 39½-hour week, every other Saturday free, 2 weeks sick leave, 2 weeks vacation, retirement plans; mileage allowance 8c, automobile not required; salaries: educational director, mental hygiene consultant, $4,020-$4,380; nurse physiotherapist, $3,840-$4,200; prepared public health nurses, $3,060-$3,420. Write to Mable E. Grover, Director, Division of Nursing, Columbus Department of Health-Instructive District Nursing Association, City Hall, Columbus 15, Ohio.

WANTED—Qualified experienced supervisor for challenging position in Northwest; retirement plan, social security, 5-day week, four weeks vacation; car optional; salary range $300-350, depending on qualifications. Write to Mary I. Breneman, Director, Visiting Nurse Association, 1008 S.W. 6th Avenue, Portland 4, Oregon.

WANTED—July 1, 1952; director for Springfield-Whitemarsh Visiting Nurse Association, Flourtown, Pennsylvania, 15 miles from Philadelphia; generalized service; 5-nurse staff; car provided; retirement plan; minimum salary $4,032; minimum requirement: PHN certificate and 2 years experience as supervisor in public health agency. Write to Mrs. Frederic Ballard, Jr., Northwestern Avenue, Philadelphia 28, Pennsylvania.

WANTED—Tuberculosis nurse with some experience and teaching ability to be nursing director of a 45-bed tuberculosis hospital; salary and full maintenance provided. Apply to City of Columbus Health Department, Columbus, Georgia.

WANTED—Staff nurse; Sandusky City and Erie County Health Department. Write to Miss Nettie E. Witter, Senior Nurse, City Building, Sandusky, Ohio.

WANTED—Instructor and assistant to executive director; undergraduate student program; 7-nurse staff; generalized service, bedside nursing and family health; 40-hour week, retirement, social security, and hospitalization plans; salary dependent on preparation and experience. Write to Middletown District Nurse Association, Inc., 51 Broad Street, Middletown, Connecticut.

WANTED—Public health nurses, New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2,650; 37-hour week, liberal vacation and sick time allowance, pension rights, inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, New York.

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